Social Acceptance Project
Assessment of the 1997 DOH Family Planning Clinical Standards Manual

(Commissioned by the Academy for Educational Development, with support from United States Agency for International Development)

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December 12, 2003
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ACKNOWLEDGEMENT

The research team is most grateful to the Academy of Educational Development, for commissioning the Yuchengco Center for this project, and to the United States Agency for International Development for its financial support. In particular, we wish to acknowledge the generous support of Ms. Eleonora de Guzman, Chief of Party, and Dr. Cecilia Lantican, Deputy Chief of Party.

We also give special thanks to Dr. Ricardo Gonzalez, for making the different manuals available, and for his insights and advice related to the evaluation of the manual.

The Center also thanks the different family planning service delivery agencies that provided information for our research: government health units in Metro Manila, Davao, and Iloilo; Philippine General Hospital and Jose Fabella Hospital; Family Planning Organization of the Philippines, Friendly Care and the Institute of Maternal and Child Health; and midwives from all service delivery points (BHS, CHO, RHU and hospitals) from Tawi-tawi and Zamboanga.

We also acknowledge the directors of the Department of Health for sharing their views as well as their resources during the research team's interviews and gathering of materials: Dr. Myrna Cabotaje, Dr. Florencia Apale, Dr. Divina Capuchino and Dr. Honorata Catibog.

Lastly, the team extends its appreciation to the participants of the project's validation seminar on 12 December 2003, for their insights, comments and suggestions that were very useful in improving our research report.

Executive Summary

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In October 2003, the Academy for Educational Development (AED) with funds provided by the United States for International Development (USAID) commissioned the Yuchengco Center (YC) to assess the 1997 Department of Health (DOH) Family Planning Clinical Standards Manual. The ultimate aim is to develop an updated manual that is relevant and responsive to changing technology and the policy environment. Specifically, the study aimed to:

a. assess the various policy issuances of the DOH and their implications for FP service delivery and training of providers;
b. to compile, consolidate, analyze and compare the various FP manuals developed for local use taking into consideration the thrust, relevance, presentation, technical skills imparted, acceptability and appropriateness;
c. to elicit the perceptions and attitudes of the policy makers, programme managers and service providers at all levels (DOH, NGO clinics, BHSs, RHUs, CHOs and hospitals) toward the manual in terms of its utilization, appropriateness, clarity, substantive value, needs and congruence with the new policies and guidelines; and
d. to determine the FP service provision needs based on the review of DOH policies and the various manuals used and perspectives of programme managers/planners, and service providers with the end view of developing a useful and meaningful manual.

The methodology adopted included: a) the review of sequential policy issuances of DOH relevant to family planning; b) analysis and comparison of various manuals adopted by the different service delivery points included in the study; c) conduct of key informants' interviews of DOH programme directors; and d) focus group discussions of managers and providers from different service delivery points. Fourteen focus group discussions were carried out in selected government service delivery points in Metro Manila, Davao and Iloilo; service hospitals and NGO clinics.

The results were summarized and presented. The issues and concerns arising from the results obtained were as follows:

1. Impact of devolution on the local level adoption of the manual. Under the devolved programme, DOH will be responsible for the provision of technical guidelines and standards while the local governments will provide financial assistance to the local health programmes and see through their operationalization. In many cases, the utilization of the manual hinges largely on the method endorsed by the local government leader.

2. Inability to operationalize the paradigm shift from FP to RH. While there is a general understanding of the policy shift from FP to RH with its ten constituent elements, the

interactive linkages among the elements have not been discussed and no particular guidelines have been provided to operationalize the provision of quality, integrated FP services in collaboration with LGUs, NGOs and the private sector. In fact, some service providers did not appreciate the inclusion of the vision and goals of FP in the manual as they are not deemed pertinent to their provision of services.

3. Inadequate distribution of the manual. Despite the non probabilistic nature of the selection of the service delivery points in government facilities, of the ten SDPs initially visited, staff members in four SDPs have not encountered the manual, three of which are Luzon based. Further substitution did not yield the desired results as the clinics identified in the provinces adjoining Metro Manila did not have the manual.

4. Use of different manuals in service provision. It was noted that the different SDPs included in the study are using two or more manuals with the staff indication that the other manuals are more up-to-date, comprehensive, succint in presentation and user friendly.

5. Inability to comprehend the FP vision, goals and objectives to secure commitment to its implementation at the local level due to lack of guidelines that explain the FP linkage with the other elements and the operationalization of basic tenets. A few service providers suggested dropping the first chapter of the manual altogether since the FP policy and framework are not relevant to their task.

6. Staggered distribution of the manual. Many service delivery points have not obtained the manual and some have just received it a few months ago. This calls for a review of its storage and distribution.

7. Lack of orientation on the use of the manual. The providers were not oriented on the use of the 1997 manual. In the training, the competency based training (CBT) manual was used. Thus, the service providers claimed that they vary in their interpretation of the procedures in diagnosis, service provision and management. No refresher courses were provided. Besides, the congruence between the CBT manual and the 1997 manual has yet to be assessed.

8. Some areas are deemed comprehensive in terms of guidelines provision such as infection control, syndromic approach to STI diagnosis, description of FP methods, and their advantages and disadvantages. An area that is considered not relevant is the orientation on the, vision, goal and objectives of FP programmes. Some felt that the information on counseling is not detailed enough to guide the providers since the misconceptions and misinformation related to the different methods have not been incorporated. Besides, ways of dispelling these have not been discussed.

9. The manual has not been updated. Other FP areas not discussed include Standard Days Method, myths and misconceptions related to FP methods, emergency contraception, acetic acid wash, missed pills back-up and autodisable syringes. The WHO eligibility criteria are not adopted in screening of potential FP clients. Besides, discussions on

diaphragm, norplant and female condom are considered irrelevant by the providers since they are no longer provided in the SDPs. However, in the light of the proposed use of the planned revised manual by both GO and NGO entities, these methods will be retained. Other areas suggested to be considered include NSV, spinal anesthesia in BTL, laparoscopy, and waste management. Males and adolescents' FP needs are not included.

10. The presentation of the manual is not clear enough as it lacks the illustrations and algorithms required to guide the provider in service delivery. The manual is considered heavy, bulky and lengthy. Lay out is space consuming.

11. The referral system has not been established. Where and how referrals are to be made have not been included.

12. Quality elements have not been incorporated. Given the DOH policy statement regarding quality service provision, the constituent elements of quality of care have not been incorporated such as information given to clients, informed choice, technical competence, interpersonal relations and referrals.

Recommendations

The recommendations could be categorized as:

a) those related to the adoption of the manual;
b) those related to its distribution;
c) those related to its improvement (content and presentation); and
d) those related to its monitoring.

A. Those related to the adoption of the manual

1. Launch a largescale information campaign on Reproductive Health, in general and Family Planning, in particular since many local government leaders and health service providers do not have sufficient comprehension of the RH paradigm, the niche of FP and its interactive linkages with the other elements. Most service providers are knowledgeable of the ten elements but their interactive linkages have yet to be explained.

2. Operationalize the modalities in the National Family Planning Strategy particularly the integration with various services in a holistic fashion. Disseminate guidelines to concerned agencies.

3. Develop a plan for the enhancement of knowledge and awareness of the key influentials (local government leaders, programme managers and providers) of the importance and relevance of the manual (IEC campaign).

B. Those related to the dissemination and distribution of the manual

4. Develop a modality for largescale dissemination and distribution of the manual to ensure that the service delivery points receive the manual at the same time. Ensure its implementation.

C. Those related to the improvement of the manual

5. Review and rationalize the current manuals being used by various agencies and draw from their respective strengths and the recommendations of the DOH directors and service providers to ensure that a manual that draws from the merits of various sources and responds appropriately to current and emerging concerns is produced and adopted.

6. Improve the manual on the basis of the following recommendations:

a) Ensure clarity in presentation through
   - use of colored illustrations and pictures particularly in the presentation of pathologic conditions such as STIs and discussion of topics
   - use of larger fonts
   - use of bullets to summarize key points
   - use of checklists for each method's medical eligibility
   - precise, concise and simple words
   - presentation of the anatomy and physiology of the reproductive system

b) Improve contents by:
   - addressing emerging concerns such as: adolescent FP needs, male involvement in FP, and gender sensitivity in service provision. For male services, aside from the male methods (condom, vasectomy), information and behavioral change communication related to male responsibility need to be incorporated. For adolescents, counseling and information on the adverse effects of irresponsible sexual behaviour, teenage pregnancy, abortion and STIs may be included.

   - Updating and expanding service provision to include BTL through spinal anesthesia, use of autodisabled syringe, emergency contraception (e.g. FP in rape cases), dispelling myths and misinformation regarding methods, missed pills back-up, and TCu 380A IUD provision

   - integrating quality dimensions in FP service provision such as information given to clients, informed choice, technical competence, interpersonal relations, and referral system (continuity of services)

   - revision of counseling procedures to adapt GATHER to the local situation of clients

- use of local case studies and situationers for ease in comprehension of service delivery and management

- inclusion of the eligibility criteria from WHO standards for the different methods

- In the light of the new policy issuances, provide a separate chapter for NFP comprising LAM, BBT, SDM, cervical mucus method, and symptothermal method.

7. Provide algorithms and flowcharts for sequencing of actions in provision of each FP method from screening, FP service provision, management of complications/side effects, follow-up and referrals for the different methods.

8. Revise reports, records and forms to conform to the Sentrong Sigla standards. Train providers on simple tabulations and use of results for programme improvements.

9. Ensure uniformity in service provision standards in GO and NGO clinics as well as hospitals since client segmentation based on affordability is planned.

10. Prepare summary tables for every chapter.

11. Ensure congruence between training and service delivery by comparing the training and the service provision manuals or simply prepare a companion training manual to the planned revised manual

Monitoring

12. Institute a monitoring mechanism for tracking the utilization of the manual and providing backstopping in its use.

13. Continually update the manual with the advent of new technologies and emerging needs (if possible, every three years).

14. Maintain continuous dialogue with the end users and programme planners to ensure its sustained usage.

Table of Contents

Glossary

AED	Academy of Educational Development
AIDS	Acquired Immuno-Deficiency Syndrome
BBT	Basal Body Temperature
BCC	Behavioral Change Communication
BHS	Barangay Health Station
BHW	Barangay Health Workers
BTL	Bilateral Tubal Ligation
CBT	Competency-Based Training
CD	Compact Disc
CDLMIS	Contraceptive Distribution and Logistics Management Information System
CFEH	Center for Family and Environmental Health
CHD	Center for Health Development
CHO	City Health Office
CLEAR	Clinic facilities, Logistics, Essential staffing, Activities, Records and Reports
CMM	Cervical Mucus Method
COC	Combined Oral Contraceptives
CPR	Contraceptive Prevalence Rate
DECS	Department of Education, Culture and Sports
DED	Development Experience Documents
DMPA	Depo-medroxyprogesterone Acetate
DOH	Department of Health

DSWD	Department of Social Welfare and Development
FGD	Focus Group Discussion
FP	Family Planning
FPOP	Family Planning Organization of the Philippines
GATHER	Greet, Assess, Tell, Help, Explain and Return
GO	Government Organization
HHRD	Health Human Resource Development
ICPD	International Conference on Population and Development
IECM	Information, Education, Communication and Motivation
IMCH	Institute of Maternal and Child Health
IPC	Interpersonal Communication
IUD	Intrauterine Device
KI	Key Informants
LAM	Lactation Amenorrhea Method
LGU	Local Government Unit
MCH	Maternal and Child Health
MIS	Management Information System
ML-LA	Minilaparotomy and Laparoscopy
MM	Mucus Membranes
NCDP	National Center for Disease Prevention
NEDA	National Economic and Development Authority
NFP	Natural Family Planning

NGO	Non- Government Organization
NSV	No Scalpel Vasectomy
PFPP	Philippine Family Planning Programme
PHIC	Philippine Health Insurance Corporation
PLS	Procurement and Logistic Service
PMAC	Prevention and Management of Abortion and Complication
POP	Progestin-Only Pills
POPCOM	Population Commission
PFPP	Philippine Family Planning Program
PLS	Procurement and Logistics Services
RH	Reproductive Health
RHU	Rural Health Unit
RTI	Reproductive Tract Infections
SAP	Social Acceptance Project
SDM	Standard Days Method
SDP	Service Delivery Point
SIP	Service/Information Provider
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
STM	Symptothermal Method
TFR	Total Fertility Rate
UNFPA	United Nations Population Fund

USAID	United States Agency for International Development
VHW	Volunteer Health Workers
VSC	Voluntary Surgical Contraception
VSS	Voluntary Surgical Sterilization
WHO	World Health Organization

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Clinical Standards Manual

1. Introduction

In 1997, USAID supported the revision of the 1993 Family Planning Clinical Standards Manual adopted by the Department of Health (DOH) in the provision of family planning services in its constituent delivery points (barangay health stations, rural health units, city health offices and hospitals). Such modification was a response to the developments in contraceptive technology and the changing policy environment in the country. Six years later (2003), there was a felt need to assess the relevance of the 1997 manual in the light of new policy issuances and emerging needs. These include:

a) the adoption of the recommendation drawn from the ICPD-Programme of Action of a comprehensive approach in the formulation, and implementation of a reproductive health (RH) policy and programme. This was embodied in the Administrative Order #1 dated January 15, 1998 focusing on the following approaches:

   - integrated services emphasizing quality and expanded coverage through partnership with local government units, non-governmental organizations and the private sectors;
   - promotion of personal responsibility, information dissemination and emphasis on freedom of choice in accessing programmes, services and knowledge base; and
   - introduction of the ten elements of RH care package composed of family planning, maternal and child health and nutrition, prevention and management of reproductive tract infections, prevention and treatment of post abortion complication, adolescent health, education and counseling on sexuality and sexual health, breast and reproductive tract cancer, men's RH, violence against women and prevention and treatment of infertility and sexual dysfunction;

b) increased emphasis on male involvement and adolescent RH;

c) greater autonomy of local governments in defining the family planning thrust in their respective areas since funding for RH programme operations including family planning is drawn from their resources; and

d) the Catholic church's and political leaders' stand on family planning specifically the promotion of natural methods.

2. Rationale for the Study

By 2003, basic questions are raised in terms of the relevance and responsiveness of the manual. These are:

1. What is the relevance of the manual and what are the implications on its substantive contents of the technological developments, changes in the policy environment and emerging needs?
2. Are there areas that need to be improved or enhanced? Are there areas to be updated or deleted?
3. Is there a need for upgrading the technical skills required of different types of providers at different levels of service delivery points (governmental and non-governmental) with the new developments?
4. What problems were encountered by the field staff in the use of the manual? How could these be addressed?
5. How is the manual disseminated? Was there an orientation on its usage? How were they conducted? Were there refresher courses?
6. What are the ways in which the manual can be improved for timely and competent service provision?

3. Objectives of the Study

The study was undertaken with the following objectives:

1. to assess the various policy issuances of the DOH and their implications for FP service delivery and the training of providers;

2. to compile, consolidate, analyze and compare the various FP manuals developed for local use taking into consideration the audience reach, thrust, relevance, presentation, technical skills imparted, acceptability and appropriateness. There is a need to assess the relative merits of the various manuals and arrive at a meaningful set of recommendations toward an appropriate service provision guide;

3. to elicit the perceptions and attitudes of the policy makers, programme managers and service providers at all levels (DOH, NGO clinics, BHWs, RHUs, CHOs and hospitals) toward the manual in terms of its utilization, appropriateness, clarity, substantive value, needs and congruence with the new policies and guidelines of DOH; and

4. to determine the FP service provision needs based on the various perspectives with the end view of developing a useful and meaningful manual.

4. Methodology

A two pronged approach was applied:

a) review of relevant documents/materials such as the sequential policy issuances of the Department of Health since 1998 and the various FP manuals being used by the different service delivery points; and
b) conduct of key informant interviews of programme directors from DOH and focus group discussions with SDP managers and service providers.

Attempts were made to locate other materials such as evaluations of FP manuals, programme, projects and initiatives with FP components but the inquiries and search in libraries and other offices did not yield the needed information.

The procedure used in this study was basically qualitative and the choice of service delivery points was purposive and non-probabilistic. The purpose of the study was not to establish utilization levels nor trends but to undertake a contextual assessment of the manual, its comparison with other manuals, and perceptions of its relevance as drawn from key informants' interview and focus group discussions.

4.1 Compilation and review of policy issuances and FP manuals

The sequential DOH administrative orders with relevance to FP from 1998 onward were compiled and assessed in relation to the training needs of providers.

Seven family planning manuals currently being used by the service delivery points have been identified (See Section 5.3). In addition, specialized manuals were collected such as: (a) Guidebook on Adolescent and Youth Health and Development Programme; (b) Guidelines on Minilaparotomy and (c) Family Planning Counseling Handbook. However, these three manuals were not reviewed since the focus of the study was the provision of a wide variety of FP services.

4.2 Conduct of key informants' interviews and focus group discussions

4.2.1 In-depth interviews were conducted with four programme directors from the Department of Health representing the National Center for Disease Prevention (NCDP) and the Center for Family and Environmental Health (CFEH). NCDP is the management arm of the DOH covering Family Health and its constituent programmes such as women's health, family planning, RH and breast cancer, among others while the CFEH takes charge of health operations of the women's health and development programme under the RH as the umbrella.

4.2.2 Focus group discussions (FGDs) were conducted with the staff of selected government service delivery points in Luzon, Visayas and Mindanao. Besides, FGDs were conducted among the staff of two service hospitals (Philippine Genera Hospital and J. Fabella Memorial Hospital) and three NGO clinics (Friendly Care, IMCH and FPOP).

In addition, it was suggested that questionnaires be distributed to the government midwives participating in a training workshop in Zamboanga del Sur and the IMCH providers attending a seminar in Manila.

4.3 The Research Instruments

The research instruments consisted of: (See Annex I)

a) focus group discussion guide;
b) key informants' interview guide; and
c) self administered questionnaire.

4.3.1 Focus Group Discussion Instruments

Focus group discussions were designed to elicit the perceptions and attitudes of programme managers and providers related to family planning, in general and the 1997 manual, in particular. Such discussions aimed to extricate the issues and concerns related to the current FP service provision and provide inputs to the improvement of the manual. Items included in the guide are:

a) type and schedule of family planning services provision;
b) training on use of the manual
    - when and how manual was acquired
    - orientation on use of the manual
    - adequacy of orientation for provider to be able to deliver services
c) comments on the content of the manual
    - technical guidelines for the provision of specific FP services
    - chapter(s) consulted most and least
    - specific relevant FP areas not dealt with in the manual
    - changes in FP activities that were not reflected in the manual
    - weaknesses, strengths, areas for improvement, deletions and additions
d) recommendations for updating and revision of the manual focusing on:
    - clarity in presentation
    - completeness in coverage
    - technical sufficiency
    - capacity for addressing emerging concerns
e) other manuals used: perceived merits, limitations and advantages

4.3.2 Key informants' interviews were conducted among the concerned DOH directors to explore the policy perspective in FP service provision, determine perception of the manual, and elicit ways by which it can be improved to respond to changing needs.

Items sought were:
a) mandate and activities of the respective division of respondents
b) division's link to FP services; center's tasks relative to FP

c) involvement of office in FP
d) changes in policies affecting FP since 1997
e) operationalization of shift from FP to RH
f) changes in FP service provision since 1997
g) manual being adopted by DOH and perception of how it is able to meet the evolving needs in FP service provision
h) weaknesses and strengths of manual
i) suggestions for improving the manual
j) other manuals adopted since 1997
k) recommendations related to:
    - clarity of presentation
    - completeness of coverage
    - capacity to address emerging concerns
    - special concerns – adolescents, males, male provision of services

4.3.3 Questions raised in the self administered questionnaire were basically similar to the guide in the focus group discussion.

4.4 Pretesting

4.4.1 The FGD Guide was planned to be pretested in the Manila City Health Office. However, since the CHO is not using the manual, the pretesting shifted to the San Isidro Health Center in Pasay City. The interview results from the SDP were incorporated in the report.

4.5 Response Distribution

4.5.1 Focus Group Discussions

The provinces selected for the study were Laguna in Luzon, Iloilo in the Visayas and Davao in Mindanao. It was planned that one municipality will be selected from each province with the Rural Health Unit and one Barangay health Station staff selected for the FGDs. Besides, one city health office from the province will be chosen. Contacts were made with the Provincial Health Offices of Iloilo and Davao to assist in the selection of the FGD sites. For Laguna, the UP College of Nursing staff suggested Nagkarlan where they have a field station and the Sta. Cruz City Health Office. The selected SDPs in Laguna were not using the manual, The government health units from Metro Manila, Davao and Iloilo that participated in the FGDs were:

Metro Manila	San Isidro Health Office, Pasay City
Davao	Tomas Claudio Rural Health Unit
	Bunawan Barangay Health Station
	Davao City Health Office
Iloilo	Mina Rural Health Unit
	Barangay Tularokan Health Station
	Jaro City Health Office

Replacement of Laguna by Cavite, however, demonstrated that the municipalities selected (Imus and Silang) were not using the manual. Further inquiries in Bulacan and Batangas did not yield positive results.

Among the service hospitals chosen, PGH and J. Fabella Memorial Hospital are using the manual while the Quezon Memorial Medical Center does not have it. All three NGO clinics (IMCH, Friendly Care and FPOP) are using the manual.

To augment the data base, it was suggested that self administered questionnaires be distributed to the midwives participating in a training workshop in Zamboanga del Sur. The midwives represented the various service delivery points in Tawi-Tawi, Zamboanga del Norte and Zamboanga del Sur. From the 55 filled out questionnaires, only 15 (27.3 percent) reported using the 1997 manual. However, the response obtained from the questionnaire was found inadequate. Hence, a decision was made to involve them in one focus group discussion. Eleven midwives participated in the FGD.

In addition, the IMCH office offered to distribute self administered questionnaires to the midwives from their various clinics in Metro Manila who were attending a seminar in the head office. Twenty two individuals received the questionnaire but lack of time prevented them from filling out the questionnaire adequately. Instead, 7 midwives participated in the focus group discussion facilitated by the project team.

All in all, there were 14 FGDs and 4 key informants' interviews. The distribution of these SDPs is given in Map 1. The distribution of FGD respondents is given in Annex II and the list of key informants is given in Annex III. A detailed distribution of FGD respondents and the service providers utilizing the manual in each clinic is provided in Annex IV.

5. Research Results

5.1 Review of DOH Policy Issuances

Between 1998 and 2001, several policy directives were issued by the Department of Health which shifted the milieu from family planning toward a comprehensive and integrated reproductive health framework with FP as one element and more recently, the emphasis on natural family planning methods.

5.1.1 On January 15, 1998, Administrative Order IA was issued by the Secretary of Health to establish the Philippine Reproductive Health Program which cited the 1994 International Conference on Population and Development (ICPD) statement emphasizing the RH approach. Such policy called for broadening the policies and programs beyond family planning and the promotion of an RH approach in dealing with the health concerns of both men and women by empowering them to lead healthy and productive lives. The rationale for the adoption of the RH approach include:

- provision of high quality care, and
- enhancement of effectiveness and efficiency of service delivery

Operationalization of the RH perspective in the DOH parlance means:

- pursuit of common RH objectives through convergence of efforts
- design and implementation of RH care services that are family and woman centered at the same time emphasizing men's roles and needs in reproduction
- adoption of the life cycle approach
- cross cutting gender across all elements of RH
- incremental strategy in RH service provision
- cooperation and collaborative efforts with other agencies

The elements of the RH care package were identified as:

1. Family Planning
2. MCH and Nutrition
3. Prevention and management of abortion complications
4. Prevention and management of RTIs including STDs, HIV and AIDS
5. Education and counseling on sexuality and sexual health
6. Breast and Reproductive Tract Cancers and other Gynecological conditions
7. Men's Reproductive Health
8. Adolescent Reproductive Health
9. Violence Against Women
10. Prevention and Treatment of Infertility and Sexual Disorders.

The RH framework will serve as the guide for the DOH's policy and programme directions by integrating the services, programs and projects delivering the constituent reproductive health services.

All DOH RH services, programs and projects delivery RH services were integrated under the Office of Special Concerns (OSC) at the national level. At the regional level, the Regional Health Offices were directed to pattern their structure after the national system to carry out the functions and oversee the programme at the regional and LGU levels. It took some time to sharpen and refine the RH framework.

5.1.2 Administrative Order 24-A was transmitted in March 2000 aimed at strengthening the DOH Reproductive Health Programme. The major features of this directive are:

- integration of services, with emphasis on quality and expansion of coverage through partnerships with LGUs, NGOs and the private sector within the Health Sector Reform Agenda; and
- improvement of the general health of all Filipinos through promotion of personal responsibility and empowerment of communities to exercise RH rights within the National Objectives for Health framework. In this order, the guiding principles, vision, mission, goal, general and specific objectives, targets and elements of RH are specified.

The DOH outputs by 2004 were specified as:

- the creation of awareness and demand for RH services
- provision of integrated quality RH package at all retained hospitals and LGU health service facilities through capacity building and improved standards and regulations
- strengthened partnerships in the provision of RH services
- incorporation of RH programme in the academic curriculum of medical and allied medical professions
- development of an integrated system of reporting and recording
- inclusion of RH service in health financing and social insurance.

The implementing agency at the national level was the Center for Family Health under the cluster on Disease Prevention and Control. The multisectoral Contraceptive Independence Initiative was the priority of the national programme. A National RH Management Committee was convened composed of the head of the Center for Family Health, the programme manager of five programmes, zonal coordinators, and representatives from NGOs, POPCOM, DSWD, NEDA, DECS, the academe and the Center for Health Promotion. The Regional Health offices were directed to organize the multisectoral Regional RH Programme Management Committee to oversee the implementation of regional and LGU programmes. The Center for Family Health was to spearhead the operationalization of RH programme particularly the establishment of linkages among the ten elements. To ensure high standards in service delivery, the

programme was to be the major component of the DOH Quality Assurance Programme, "the Sentrong Sigla Movement".

5.1.3 On September 16, 2001, Administrative Order no.49, 2001 was issued entitled Adoption of the Standard Days Method (SDM or Necklace Method) as Additional NFP Method for the Philippines FP Programme. In this memorandum, it was stated that "there remains a significant unmet need for family planning which partially can be met by expanding the availability and accessibility of NFP services. Its full potential could be tapped for those looking for a method that best suits them." The DOH in partnership with the Institute for Reproductive Health tested a new natural family planning method known as Standard Days Method or "Necklace Method" which is now officially adopted in the country and mainstreamed in the national Family Planning Programme. It is a simple method primarily based on abstinence from unprotected intercourse on days 8-19 for women whose cycles are between 26 to 32 days to avoid pregnancy. A necklace is provided with 32 plastic beads representing the different phases of the menstrual cycles. The incorporation of SDM was to be implemented by phases with the method to be made available in the various service delivery points of Metro Manila initially.

5.1.4 Administrative Order 50-A, on September 17, 2001 was circulated entitled the National Family Planning Policy. In this issuance, FP was reiterated as one of the critical elements of the RH programme. Emphasis was placed on the refocusing of the Philippine FP Programme from a demographically driven approach to one that promotes the health of all Filipinos with special focus on women and children. The FP interventions center on the following methods:

1. Natural Family Planning (NFP)
2. Pills
3. Condoms
4. Hormonal Injectables/ Depo-Medroxyprogesterone Acetate (DMPA)
5. Intrauterine Device (IUD)
6. Lactational Amenorrhea Method (LAM)
7. Voluntary Surgical Sterilization (VSS):
   - Bilateral Tubal Ligation (BTL)
   - Vasectomy

FP shall be promoted in the country as a: a) health intervention; b) means to prevent high risk pregnancies; c) means to reduce maternal deaths; d) reproductive right for women; e) means to reduce poverty; and f) move toward responsible parenthood. It implies that DOH, in partnership with Local Government Units (LGUs); NGOs and the private sectors shall ensure the availability of FP information and services to men and women who need them. Specific objectives were set in terms of reduction of Maternal Mortality Rate (MMR), Infant Mortality Rate (IMR), <5 mortality rate and Total Fertility Rate (TFR), and increase in Contraceptive Prevalence Rate (CPR). The DOH Center for Family and Environmental Health was designated as lead agency for FP management with responsibility for:

- policy, standards, guidelines, plan, program and project development which shall be consistent with the DOH major policies in the Health Sector Reform Agenda, National Objectives for Health and Sentrong Sigla Movement;
- inter-agency collaboration and coordination of FP activities and other initiatives through established mechanisms;
- provision of required technical assistance to the Centers for Health Development (CHD) and partner agencies;
- generation and mobilization of resources for FP; and
- ensuring the availability of FP commodities.

In addition, the Center will:

- explore the most appropriate policies and measures concerning funds generation, mobilization, programming and utilization in support of Contraceptive Interdependence Initiative;
- expand FP insurance benefits to include other FP services under the National Health Insurance Programme;
- ensure implementation of FP services by DOH retained hospitals, LGUs, other NGOs, private sectors; and
- integrate monitoring, evaluation, research and development in the FP implementation process.

To improve access to quality FP services:

a. quality care shall be promoted and ensured in the provision of FP services.

b. provision of Family Planning services shall be integrated with other services related to Reproductive Health.

c. in urban and rural poor communities, a home service delivery strategy should be implemented to further increase access of potential clients to FP services.

d. volunteer health workers adequately trained for FP should be recruited to support the home service delivery strategy. VHWs should be properly supervised and regularly monitored by organic health personnel of the LGU and/or the CHD.

e. the following FP method mix shall be made available in all government health service facilities and encouraged in private facilities: pills, condoms, injectable, IUD, NFP, LAM, bilateral tubal ligation (BTL) and vasectomy.

f. the provision of Voluntary Surgical Sterilization (VSS) services should be done according to DOH standards. It shall be promoted as the first option for couples who have expressed completion of their desired family size.

g. accredited health facilities shall claim reimbursement from the Philippine Health Insurance Corporation (PHIC) for VSS services performed on National Health Insurance Program cardholders.

h. social marketing programs for FP commodities and services should be encouraged and supported.

Training

Enhancement of Capability-building for FP service providers

1. All categories of FP personnel such as field supervisors/coordinators, program managers and service providers (doctors, nurses and midwives) both in the public and private sectors, shall undergo training on the relevant training courses utilizing the prescribed/accredited curricula in order to maintain the provision of quality services. Service/Information Providers (SIP) shall be equipped with minimum training requirements on the 10 elements of RH.

2. All training curricula, training evaluation standards on FP shall be developed/updated in collaboration with the Department of Health – Health Human Resource Development Bureau (HHRD) with technical assistance from the CFEH.

3. Only certified-trained providers will be allowed to provide FP services.

4. Trained FP service providers shall undergo periodic refresher courses/training at least every 5 years to update on recent development and trends.

5. Only accredited training institutions with certified training staff should manage and conduct FP training courses. Post training follow up of participants and evaluation of training shall be the responsibility of CHD, NGO and LGU trainers in collaboration with corresponding training institutions.

6. Accreditation of training curricula and other materials shall be done by FP accreditation body composed of trainers from HHRDB and CFEH as members while the accreditation of training institutions and trainers shall be the responsibility of a regional accreditation body composed of training experts from the public and private sector.

Logistics

Improvement of logistics management

1. The Procurement and Logistic Service (PLS) shall ensure that quality and medically safe contraceptives are available and accessible through a system called Contraceptive Distribution and Logistics Management Information System (CDLMIS). The PLS shall be responsible for facilitating the release of contraceptives from the Bureau of Customs and delivery of same to various consignees.

2. The PLS shall ensure the accurate and timely forecasting of contraceptives with technical assistance from CFEH.

Other areas considered are research and information base through the improvement of MIS for evidence based decision making; Information, Education, Communication and Motivation (IECM) through intensification of efforts; health financing through mobilization of more investments for FP; quality assurance applying the concepts and standards set by Sentrong Sigla; and monitoring and evaluation through quarterly FP review; semi-annual programme review; annual evaluation report; annual evaluation and planning workshop; and the FP directional and 5-year strategic plan including annual status reports.

5.1.5 On June 5, 2002, the National NFP Strategic Plan for years 2002-2006 was introduced through Administrative Order 125. This plan focuses on the policies, standards, strategies and activities needed to mainstream the Natural Family Planning (NFP) methods within the PFPP for years 2002-2006. This plan shall apply to all government and non-government institutions providing services in family planning, safe motherhood, and other reproductive health services. This plan will integrate and reformulate all previous related policies, guidelines and instructions to provide a more comprehensive, practical and operationally relevant framework on mainstreaming NFP. This plan shall also guide the utilization of the funds provided for this purpose.

The traditional methods of NFP include rhythm or calendar method and withdrawal while the modern methods are the cervical mucus method, basal body temperature, symptho thermal method, and lactational amenorrhea method. General policies guide the mainstreaming and provision of NFP services. In terms of training:

- a Basic Course on Modern NFP Methods shall be provided by DOH and other DOH-accredited NFP training institutions to all health facility staff and volunteers who are involved in provision of services for FP, safe motherhood, and other reproductive health elements

- NFP shall be incorporated as an integral part of the Basic FP Course of the DOH as soon as there are available trainers at the national, regional and local government levels. The Basic Courses already incorporating NFP shall be called the Enhanced FP Course.

- health facility staff who have previously completed the Basic FP Course may go through the Basic Course on Modern NFP Methods only; while those who have not yet been trained in the Basic FP Course shall be trained using the Enhanced FP Course.

- volunteers, especially from religious groups, who may want to be trained only on NFP may be given only the Basic Course on Modern NFP Methods.

For service delivery:

- all modern NFP methods shall be routinely and thoroughly explained and offered to couples/clients before they make their final choice. The couple shall be allowed to select a method based on their preferences and lifestyle. This means that no NFP method shall be 'positioned as a better method" over other NFP methods in any predefined situation.

- due to limited resources, the logistics to be provided through DOH shall be limited to essential training and counseling supplies and materials such as manuals, modules and low-cost charts. The cost of devices such as thermometers (preferably regular thermometers) and others such as necklaces shall not come from funds of the DOH since these are better purchased by the user to allow choice.

- all DOH facilities especially the DOH retained hospitals shall incorporate NFP in their reproductive health services especially in maternal and child health clinics.

Training and certification of frontline health providers: Since the availability of competent and well-oriented trainers is key to the success of NFP mainstreaming, focus will be on training or, if needed, retraining of midwives, nurses, doctors at all levels especially the local government level. Private practitioners shall also be recruited within the church network to include NFP in their services. Volunteer couples and Barangay Health Workers shall also be trained in NFP services.

5.1.6 Administrative Order 153 issued on September 25, 2002 provides implementing guidelines for the creation and operationalization of outreach/itinerant teams for voluntary sterilization services.

The itinerant VS teams should be organized in all DOH regional hospitals and medical centers, which will serve as the base of the team. There should be a minimum of two VS teams per hospital. The chief of the respective regional hospital or medical center through the chairperson of the Obstetrics and Gynecology Department will be responsible for the creation and organization of the teams. A hospital order should be issued to create and operationalize the itinerant VS teams.

- If the itinerant VS site is a hospital (DOH or LGU managed), it should make available an operating room that complies with minimum requirements for performing minor surgery, tubal ligation, and vasectomy procedures.

- If the itinerant VS site is a health center or in a non-hospital venue, it should be refurbished to comply with the minimum requirements for providing ML-LA and No-Scalpel Vasectomy (NSV).

- The itinerant VS surgeons will be responsible for screening and final selection of clients, verification of informed consent, and assurance of quality of care, including proper infection prevention practices.

- The provision of voluntary sterilization should be performed in accordance with the DOH approved minilaparotomy under local anesthesia for female clients, and no-scalpel vasectomy technique for male acceptors.

- Members of the itinerant VS team must ensure proper examination and monitoring of clients in the immediate post-operative period and upon discharge.

- FP counseling should be provided by trained staff of the outreach VS site. Counseling activities should be done regularly and during the scheduled outreach VS services.

- The staff of the outreach VS site should provide both verbal and written post-operative instructions including follow-up schedules to the client prior to discharge.

- They shall keep charts/records of all BTL and vasectomy clients: complete names, age, address, number of children and the date the procedure was performed.

- A medical personnel should be made available and tasked to do follow up visits.

5.2 Implications of the Policy Issuances on the Provision of FP services and Training Requirements

Based on the seven aforementioned directives, the following implications for the provision of FP services are discerned:

5.2.1 Within the RH framework, the integration of FP with the other elements of RH needs to be operationalized. How could the interactive linkages among the various elements be described at the level of implementation? How can viable partnerships with LGUs, NGOs, and private sector be forged in FP service implementation within the RH frame? How can informed choice be exercised by the clients?

5.2.2 Considering that the Necklace Method has been incorporated as an NFP method, there is a need to improve the information provision to potential clients. Field testing of the method needs to be done to determine its acceptability, utilization pattern, continuation and failure rates. These are important elements in training. Besides, BCC strategies need to be adopted to promote its usage.

5.2.3 As clearcut guidelines have been issued related to the implementation of the national family planning programme, the need to monitor its implementation is underscored.

5.2.4 Capacity of providers needs to be enhanced through responsive, appropriate and needs based training programmes. Assessment of training capacity of the service providers should be geared toward the specific competencies required for service provision. Such assessment should be considered in the development of new training programmes.

5.3 Review of Manuals

In this section, the seven manuals currently used by the various Family Planning clinics in the study are reviewed and assessed in terms of their relative strengths and weaknesses. The list of manuals reviewed is given in Annex VI.

5.3.1 The 1997 Clinical Standards Manual was published by the Department of Health with the support of the United States Agency for International Development (USAID). It is comprised of seven chapters. The first chapter deals with the Philippine Family Planning Program (PFPP) including policies, guiding principles, vision, goals, objectives, strategies, program components and benefits. The second chapter focuses on counseling in FP. It discusses the role of counseling in FP, essentials for counseling, skills needed, the GATHER technique, and key messages in FP and RH. The next chapter is about the Basic RH Care Visit. Aside from stating its nature and purpose, client history, general physical examination, client education, laboratory and clinic examinations are presented. It also contains the Family Planning service records and other recording forms. Chapter 4 discusses both the program and non-program FP methods. The program methods are lactational amenorrhea method (LAM), natural FP, hormonal contraceptives, intrauterine device (IUD), condoms, and voluntary surgical contraception. The non-program methods are implant contraceptives, diaphragm, female condom, spermicide barriers, and calendar method. Each method is presented in terms of its mechanism of action, indications, advantages, disadvantages, contraindications/ precautions, counseling, client history and physical examination requisites and client education. The next chapter is concerned with Reproductive Health Care covering adolescent fertility/ sexual health, mother-baby care package with information on detection of pregnancy and prenatal care, labor and home delivery, postpartum care, contraception for women over 35 years of age (combined oral contraceptive, progestin-only contraceptive, IUD, condom, VSC), knowing and treating reproductive tract infections/ STDs (Syndromic Approach), management of infertility, and detection and management of cancer of the cervix/ uterus. Chapter 6 deals with infection control. It starts with the definition, followed by discussion of the different protective barriers such as hand washing; asepsis of the skin and mucus membrane; gloving; decontamination and cleaning; sterilization; and high level disinfection. In chapter 7, the management of FP clinic services is described. It deals with the clinic facilities, staff, activities and logistics management.

The appendices contain a guide to return visits of NFP clients; medications that may reduce the efficiency of oral contraceptives; drugs affected by oral contraceptives, and factors and causes of infertility. It has a glossary of the medical terminologies.

The merits of the manual are its comprehensiveness, the presence of markers for ease in location of information, binders to remove specific sections; use of algorithm in the STD section; tables and graphs to summarize information; and water resistant cover. Its limitations are the weight, paper quality making it prone to easy tearing; too much space on the margins; lack of section on misconceptions and misinformation; vague NFP discussion; outdated information, and lack of discussion of the normal menstrual cycle.

5.3.2 The 1993 Clinical Standards Manual which was the precursor of the 1997 manual has eight chapters. Two chapters deal with methods of contraception used in FP clinics. The others cover FP to promote health; IEC in FP; Basic RH Care; Related RH Care; Infection Control; and Management of Clinic Services. Its strengths are in the presentation (outlined, bulleted and highlighted in bold letters, underlining important words such as never and immediately); ease in comprehension; adequate lay out; presentation such as arial fonting and nonuse of binder for ease in chapter consultation. Its limitations are lack of tables to summarize data, paper back cover which makes it damage prone, and bulk. Table 1 provides the comparison between the 1993 and 1997 manuals.

Table 1

COMPARISON OF THE 1993 AND 1997 FAMILY PLANNING CLINICAL STANDARDS MANUALS

CATEGORY	1993	1997
OBJECTIVES	▪ to define the minimum quality standards for family planning service delivery and related reproductive health care that must be provided to clients. ▪ to serve as a ready reference for clinic management, operations, and performance evaluation	▪ Similar objectives as the 1993 manual. ▪ Notable are the manual's emphasis on the latest developments in contraceptive technology and a new section on the reproductive health care services consistent with the global issues in reproductive health.
FUNDING AGENCY	UNFPA	USAID
POLICIES AND GUIDING PRINCIPLES	▪ discusses the goal of the Philippine Family Planning Programme (PFPP), concepts and benefits of FP, pregnancy related health risks, IECM, (goal and strategies), mechanics of interviewing a client, and counseling (including the GATHER technique). ▪ the discussion on IECM is more extensive than in the 1997 manual.	▪ Essentially covers the same contents as the 1993 manual but further expounds the following topics: 1. Philippine Family Planning Program (policy statements, guiding principles, vision, goals and objectives which were not discussed in the 1993 manual). This portion also identifies and discusses the components of the PFPP. IEC falls under this category. Other components include training, clinical service, and research and development. 2. Counseling is treated as a separate chapter. 3. IECM is one of the components of PFPP.

CATEGORY	1993	1997
COUNSELING	▪ discusses interviewing technique, FP counseling, essentials in counseling, skills for effective counseling, GATHER technique, and how to counteract rumors.	▪ Adds a few words in the definition of counseling, but essentially has the same definition as the 1993 manual. The essentials in counseling, skills needed for effective counseling, and counteracting rumors are similar to the 1993 manual. ▪ The GATHER technique was reworded but essentially contains the same elements and information. ▪ The Key IECM messages for FP were reworded to "Key Messages for FP and RH" but have similar contents.
BASIC REPRODUCTIVE HEALTH CARE VISIT	▪ discusses the nature and purpose of the visit, client history, physical examination, client education and laboratory examination. ▪ General Physical Examination. It is stressed that a complete physical exam is required for IUD insertion, VSC and pill prescription in the first year of use. • discusses pregnancy tests. During the period of its publication, DOH adapted the "Event" pregnancy test. Instructions on the "Event Test Strip" are included. Information on its storage, and interpretation of results are also provided. (pp.43-45) • Gram Staining Results (p 49): Interpretation of bacteria as G+, G- or cocci. • no gynecologic cytology reporting	• Has the same content as the 1993 manual but adds a section on records and reports. ▪ Nature and purpose of the reproductive health care visit are the same. ▪ General Physical Examination requisite for IUD insertion, VSC and pill intake was removed ▪ Client history is presented in an outline form. Education is added as a part of the demographic information to be obtained from the client. ▪ Family Planning history is added in the client history section. Instructions on the information to be drawn from the clients include contraceptive methods and reproductive goals of the couple. ▪ same information on self breast examination, and physical examination including pelvic

CATEGORY	1993	1997
		examination. ▪ pregnancy tests are mentioned but not discussed extensively. Instead, the reader is referred to the instructions of the manufacturer for specific pregnancy tests. Reasons for test failure are given in tabular form ▪ in the same section, "cocci" was removed". (p54) ▪ contains a gynecologic cytology report. ▪ separate section on records and reports. This includes a general description of records and reports used in the PFPP, a detailed description on how to fill up the different records and reports, definition of drop out, and samples of the records and forms to be used in the clinic. The following reports are discussed: 1. Client list for FP non surgical methods 2. Client list ledger 3. Family Planning service record 4. Client list in Family Planning Clinics 5. Supplies ledger card 6. Requisition issue voucher
NATURAL FAMILY PLANNING	▪ discusses four types of modern NFP, indications, advantages, disadvantages, contraindications, counseling, client history, physical examination, client education, complications and their management	• discusses the calendar method alone
LACTATION	▪ is included under NFP	• placed as a separate form of contraception.

CATEGORY	1993	1997
AMENORRHEA METHOD	▪ discusses the mechanism of action, mode of use and client education	
HORMONAL CONTRACEPTIVES	• discusses the mechanism of use, mode of action, indications, advantages, contraindications, guidelines, counseling, client history and physical examination, client education, drug interactions, follow-up, complications/side-effects and their management	• recommended age for POPs was changed to over 40 years instead of 35 years.
IUD	• discusses the mode of action, mechanism of use, indications, advantages, disadvantages, contraindications, counseling, client history, physical examination, provision of method, client education, follow-up, replacement, removal of the TCU-380A and management of common side-effects and complications ▪ provision of postpartum method (p 75): The IUD may be inserted 6 weeks post partum or during the immediate postpartum for normal delivery (although the retention rate is lower in the latter) and 2 months after a caesarian section.	• added the following line to the mechanism of action of the method (page 135): Thickening of the cervical mucus and thinning of the endometrial lining (progestin releasing IUDs). • added the following (page 134): 1. Prefer not to use hormonal methods 2. Have contraindications in the use of hormonal methods 3. Are breastfeeding and need contraception • added the following disadvantages to the method (page 135): 1. Requires minor clinical procedure 2. May increase the incidence of PID and subsequent infertility in women who are at high risk for RTI and other STDs (e.g. having multiple sexual partners). • contraindications in the 1993 manual were reworded to Conditions Affecting IUD Use with the same information. • uterine depth of less than 6.5cm (p. 135) was deleted as contraindication for IUD insertion. • the following were placed under special

CATEGORY	1993	1997
		precautions to the use of the method (p136) 1. Allergy to copper 2. Blood coagulation disorders while undergoing anticoagulant therapy 3. History of ectopic pregnancy 4. History of surgery of the tubes or ovaries. • The following were added under the heading Special Precautions in the Use of the Method (page 136) 1. Nulliparity 2. Symptomatic valvular heart disease unless provided with prophylactic antibiotics 3. Impaired response to infection 4. Menstrual disorders 5. Exposure to STDs • changed in the section of the provision of method. (p 136) 1. Postpartum: The IUD may be inserted within 10 minutes after the delivery of the placenta. 2. During the early post partum within the first 48-hours. After this time, it is best to wait until 6 weeks post partum when the uterus returns to its normal size.
CONDOMS	• discusses the mechanism of action, mode of use, indications, advantages, contraindications, counseling, client history, physical examination, client education, follow-up, complications/ side-effects and their management and breakage of condom	• no change. Emergency contraceptives were added as back up should the condom breaks.

CATEGORY	1993	1997
	• clarification of the shelf life of condoms (3 instead of 5 years in tropical countries)	
INJECTABLE CONTRACEPTIVES	• discusses the mechanism of action, mode of use, indications, advantages, contraindications, client history, physical examination, client education, follow-up, complications/ side-effects and their management	• the line "By reducing the number of cilia, travel time of the fertilized egg is slowed down" was removed. • the line "for those who are awaiting tubal ligation" was deleted from the indications of the method (page 140). • these lines were deleted from the contraindications of the method and added to the precautions in the use of the method (p 141): 1. Known or suspected history of cancer of the reproductive tract or breast 2. Thrombophlebitis 3. Impaired liver function • these subtopics were added (p 141): 1. When to initiate DMPA 2. Client history and physical examination (specific to the method) 3. Procedures for follow up and injection
DIAPHRAGM	▪ discusses the mechanism of action, mode of use, indications, advantages, contraindications, client history, physical examination, client education, complications/ side-effects and their management	• same
FEMALE CONDOM	▪ no discussion	• discusses mechanism of action, indications, advantages, disadvantages, precautions, client history, physical examination and client education

CATEGORY	1993	1997
VAGINAL SPERMICIDES	▪ discusses the mechanism of action, mode of use, indications, contraindications, client history, physical examination, client education, follow-up, complications/ side-effects and their management	• "indicated for the peri menopausal woman whose fertility is low and cannot use another method" was removed from the manual (p 156).
VAGINAL RINGS	▪ discusses the mechanism of action, mode of use, indications, advantages, contraindications, client history, physical examination, client education, follow-up, complications/ side-effects and their management	• the whole section on vaginal rings was removed.
CALENDAR METHOD	▪ discusses the mechanism of action, mode of use and client education	• same
VOLUNTARY SURGICAL CONTRACEPTION	▪ discusses the mechanism of action, indications, advantages, disadvantages, provision of the method, counseling, patient education, elements of informed consent, ▪ VSC (p 55): The incision of a mini lap is 2.5-3 cm. ▪ VSC (p55): The incision of the post partum mini lap is 2-2.5 cm ▪ it can be performed within the first 8 weeks after a normal delivery.	• VSC (P167): The incision of a mini lap changed to 2-3 cm • VSC (p167): The incision of a post partum mini lap is 2-3 cm • the line "It may also be done 4-6 weeks after a normal spontaneous delivery or an uncomplicated abortion" was added (p 167). • the post partum minilap indication was changed to "within 2-6 days after a normal delivery" (p 167) • the line "women with mental disorders who are helpless and have no one to protect them from sexual abuse" (p168) was removed from the indications in Female Surgical Contraception • the line "Men with severe mental disorders" (p177) was removed from the indications for male surgical sterilization • the following disadvantages were removed

CATEGORY	1993	1997
		(page 178) 1. Cannot be prescribed to those below 25 years of age and/or with less than 2 children 2. time consuming because it requires a lot of counseling to evaluate the emotional and psychological readiness of clients. 3. may mean loss of livelihood for at least one or two days.
REPRODUCTIVE HEALTH	▪ merely mentions reproductive health and does not discuss it extensively.	• contains introductory information on reproductive health, which includes adolescent fertility, sexual health, detection and management of cancer of the cervix and the uterus (p 204 – 232). • includes a discussion of the adolescent RH (p 205), and the addition of algorithms for the syndromic approach to reproductive tract infections (p 211).
INFECTION CONTROL	▪ discusses handwashing, antisepsis of the skin and mucus membrane, gloving for protection from infection, decontamination, cleaning, sterilization, high level disinfection and housekeeping	• this line was deleted from the Infection control section (page 237): "Continue to wash for 1-2 minutes, at the beginning and end of the clinic session, when grossly contaminated, before handling sterile supplies and 5-30 seconds between clients and other routines". • the gloving technique was improved in this section to include techniques for surgical procedures.
MANAGEMENT OF CLINIC SERVICES	▪ does not contain a section on records and reports. Although forms are available, these are only used for referrals.	• a whole section on records and reports was included in this manual. Clinic referrals slips were discussed as well as the Family Planning

CATEGORY	1993	1997
		service record.
VISUAL AND AUDITORY PRIVACY	▪ visual and auditory privacy was not sufficiently discussed. No information was given on the ideal counseling room.	• same
VISUALS AND ILLUSTRATIONS	▪ illustrations, because they are in black and white, do not convey the messages they are expected to transmit. (e.g. the reader will not be able to differentiate a pink from a purple cervix using black and white illustrations) No arrows are in place that would indicate the location of the reproductive parts being discussed. ▪ some illustrations are about 3 X 4 inches in size. Illustrations are clear and easily understood. ▪ Less tables and graphs to summarize pertinent data (e.g. side effects and complications)	• same illustrations are presented in smaller form • illustrations are 1 ½ x 2 inches in size (smaller than the 1993 version). Strains the eyes in scrutinizing the pictures and reading messages • more tables and graphs. • contains algorithms, which are useful in providing stepwise instructions from the screening to management of STIs.
REFERRALS	▪ referral services are vague and inadequately described. (e.g. "refer the client to a gynecologist if you suspect cancer or ectopic pregnancy" (p103). However, no specific contact information as to where and how patients could be referred could be found.	• same
RECORD KEEPING	▪ contains very little information on record keeping	• contains a section on record keeping which discusses records and reports that are to be used in the service delivery points. Information on how to fill up and use this forms is included.
FOLLOW UP	▪ information regarding when to do a follow up and what to include in here is provided	• same

CATEGORY	1993	1997
PRESENTATION OF CONTENTS	▪ contents are presented in outline and bullet form ▪ the text utilizes the whole page and not just half of it. It is symmetrical in lay out. This type of presentation makes it easy to read and draw attention to the contents of the manual. ▪ Presentation in bold format highlights key contents. Emphasis is placed on certain key words such as NOT, NEVER and IMMEDIATELY (e.g. Never use force when sounding), by underlining them. ▪ highlights diseases and methods by enclosing them in boxes using black background and white font (easier to locate) ▪ uses different fonts (Arial 12, Arial 14 and 16) appropriately to highlight key issues ▪ uses Arial font type which is easier to read because it is bigger and wider.	• paragraphs in certain sections (indentation, numbering and double spacing) • the text occupies only half of the page. The other half is space. This adds to the bulk of the manual. The lay out is asymmetrical. It draws attention to the spaces instead of the contents. • No emphasis is placed on key information which is simply presented in outline or paragraph form. No indication of the importance of the subject matter through font, color, underline, etc. resulting in monotonous presentation. • uses Arial Narrow to conserve space. (font 12).
USER FRIENDLINESS	▪ more handy and compact due to smaller size. ▪ presented in a book form. ▪ plastic binder is used which tears but does not rust ▪ no flags or markers can be found in this manual.	• too bulky and large. • binder links different sections of the manual can be removed at anytime. • metal binder is used which rusts after some time. The binder, when damaged, makes it difficult to separate the pages • flags or markers at the corner. Table of contents at the heading of each chapter is available. These make it easier to locate particular information.

5.3.3 The Johns Hopkins manual entitled Essentials of Contraceptive Technology provides a comprehensive presentation of the provision of different FP methods focusing on mode of action, advantages and disadvantages, medical eligibility check list, when the client can start the method, procedures and explanations on the use of the method. A chapter on Sexually Transmitted Infections includes their diagnosis, prevention and treatment. A major feature of the manual is the inclusion of the WHO medical eligibility criteria for the use of the different methods. Its advantages are the updated information on FP methods, the eligibility criteria, exhaustive presentation of each method with pictures; and its handiness. The disadvantages are the absence of information on male and adolescent concerns, lack of diagnostic procedures related to FP, need for cultural specificity and absence of FP forms.

5.3.4 The Basic Comprehensive FP Manual consists of seven modules covering the substantive areas related to FP. Its strength lies in the comprehensive discussion of the different methods, tabular presentation of the comparison of the methods, inclusion of self awareness and value clarification in FP services; use of binder to compile modules and chapters; and a water resistant cover. The weaknesses are limited information on referrals for AIDS prevention and control; lack of referral forms; absence of labels in certain illustrations, and bulk.

5.3.5 The Competency Based Training Manual is composed of twelve modules in three large volumes covering Introduction; Client Assessment; Infection Prevention; Counseling; the different FP methods (COC, DMPA, IUD, LAM, condom, NFP); and management of FP clinics. Its strength lies in highlighting of key information; pictures for effective visualization; comprehensive information; and succinct instruction. On the other hand, it is too long; contains some nonessential information; and bulky.

5.3.6 The Friendly Care Foundation manual contains plans and programmes, monthly reports, technical assistance reports, IEC materials, service protocols and quality assurance instructions. Its merits are comprehensiveness, inclusion of diagrams to facilitate screening of clients, discussion of GATHER technique and presentation of emergency contraception. All FP methods are included in the manual providing a wide range of choices. The follow-up system is detailed. However, the objectives are not explicitly stated nor learning expectations indicated. Referral agencies are not clearly identified and there are no illustrations of procedures. It is presented in CD form.

5.3.7 Module 1 is the introduction to FP and Women's and Children's Health which is the Overview of the Comprehensive RH and FP training manual. The strength of the module is its ability to cover the essential topics and basic information on FP; clear presentation, user friendly format and concise language. Its limitation is the emphasis on knowledge building at the expense of changing attitudes and enhancing skills. Besides, the technical competencies required for the service provider were not detailed. In Table 2, all the manuals used by the different SDPs are assessed and compared.

Table 2

Comparative Assessment of Manuals Used in Family Planning Service Delivery, 2003

NAME	DATE PUBLISHED	FUND SOURCE	COVERAGE	LIMITATIONS	ADVANTAGES
1. The Essentials of Contraceptive Technology	2001	USAID	>FP definition, scope and concerns >FP counseling and the GATHER approach >different FP Methods: a. Low- dose combined oral contraceptives b. Progestin – only oral contraceptives c. DMPA Injectable contraceptive d. Norplant Implants e. Female sterilization f. Vasectomy g. Condoms h. Intra uterine device i. Vaginal Methods j. Lactational Amenorrhea Method > each FP method is discussed in separate chapters > each FP method is discussed as follows: 1. brief description of the method and common names	• no Male RH component • no Adolescent RH component • no information on diagnostic procedures related to FP such as pap smear, biologic culture test, etc. • no description of the ideal physical setting for FP counseling • no FP guide forms for record keeping • not culture (Filipino) specific, since not all the FP methods mentioned are being utilized in the country	• has up-to-date info on FP methods like: a) Management of missed oral pills b) Oral contraceptive as treatment for reproductive problems c) Provision of DMPA injection • inclusion of WHO Medical Eligibility Criteria for contraceptive methods • each FP method is discussed in separate chapters comprehensively • has pictures which are properly labeled • small and handy

NAME	DATE PUBLISHED	FUND SOURCE	COVERAGE	LIMITATIONS	ADVANTAGES
			2. decision about the method a. how it works b. advantages and disadvantages c. medical eligibility checklist 3. starting the Method a. when the client can start the method b. procedure for providing new method c. explanation on how to use the method 4. follow up a. helping the clients during routine return visit b. managing problems/ side effects 5. important information for the user 6. answers to frequently asked questions • sexually transmitted diseases including HIV/AIDS: a. diagnosis b. prevention c. treatment		

NAME	DATE PUBLISHED	FUND SOURCE	COVERAGE	LIMITATIONS	ADVANTAGES
			7. WHO Medical Eligibility Criteria for Starting Contraceptive Methods		
2. Basic Comprehensive Family Planning Manual		UNFPA	• presented in seven modules, each containing the essential areas that the trainees should learn as FP providers. Content areas are thoroughly discussed and updated. Each module is composed of several sessions for an organized and systematic approach to training. • to facilitate its conduct, the resource requirements are discussed and transparencies included at the start of each module.	• auditory and Visual privacy for consultation is not prescribed and discussed. • discussions on referral are limited to AIDS prevention and control • referral forms are not included in the manual. • no direction for referrals for family planning. • some of the illustrations do not have labels to facilitate understanding • large and bulky	• specific objectives of the manual discussed • comprehensive discussion on the different FP methods • use of tables to compare different FP methods • inclusion of self-awareness and value clarification in the Philippine Family Planning Program Module • use of binder to compile the modules/chapters which makes removal of certain sections of the manual easier • water resistant cover for protection
3. Competency Based Family Planning Training Manual	1999	DOH FP	• composed of 11 modules in 3 large binders. The contents of the modules are as follows: 1. Introduction to Family Planning 2. Client Assessment 3. Infection Prevention 4. Counseling in Family	• too long and contains information that are not essential to day to day practice. • A lot of information are “nice to know” but not useful (e.g. how to breastfeed) • not user friendly in terms of bulk and binding. It is	• uses various techniques to highlight key information as well as visuals. By so doing, the manual attracts the eye (monotony is eliminated, and it is visually stimulating). • relevant pictures are included in certain sections. These are related to the information being

NAME	DATE PUBLISHED	FUND SOURCE	COVERAGE	LIMITATIONS	ADVANTAGES
			Planning 5. COC 6. DMPA 7. IUD 8. LAM 9. Condom 10. NFP 11. Management of Family Planning Clinics	composed of 3 large, heavy binders, containing 12 modules. • photocopied, so the back pages of the manual are not used. The extra bulk makes it inconvenient to use. One comment of a service provider was quite accurate "Kailangan mo ng trolley para bitbitin sya". (You need a trolley to carry it).	presented and permits easy recall of information. • comprehensive. It includes a check list of the resource requirements and the materials needed during the training. • very good and exhausts all the information relevant to the topic. It uses simple terms and identifies key messages with instructions on what to emphasize. • user friendly since it gives all the necessary information. It contains instructions, check lists, and algorithms. • transparencies as provided as training aid • designed with the active participation of the nurses, physicians and midwives. • with pre and post test questions and answer sheet as well as participation form, handouts and supplementary readings. • identifies the role of men or husbands, mothers, mothers in law as well as community

NAME	DATE PUBLISHED	FUND SOURCE	COVERAGE	LIMITATIONS	ADVANTAGES
					leaders in FP programs briefly (1-2 paragraphs.) • explains high risk factors as "too young, too old, too many and too close". Good for recalling information. • high lights important information. • gives an outline or introduction of what will be discussed before presenting the information. • reiterates important information by summarizing key concepts. • large graphs are given. • information regarding emergency contraceptives. • utilizes case studies which allows the providers to link the theoretical with actual situations. • table presentation of laboratory exams is comprehensive.
4. 1997 Clinical Standards Manual	1997	USAID	• divided into 8 sections (delineated by markers), comprised by 7 chapters. These are: • The Philippine Family Planning Program (Policies,	• large and bulky making it difficult to carry during daily supervision and field work. • tears easily. There is too much space. Hence, too many pages are required.	• comprehensive and provides detailed step by step instructions at every phase of the client's visit. • contains markers on the side which makes it easy to locate

NAME	DATE PUBLISHED	FUND SOURCE	COVERAGE	LIMITATIONS	ADVANTAGES
			principles, vision, goals, strategies, program components and benefits of FP) • Counseling in FP (role of couselor, essentials and skills of counseling, GATHER technique) • Basic Reproductive Health Care Visit (Nature, Client assessment, education, laboratory and records) • Methods in FP (Program and Non Program) • Reproductive Health Care Visit (RH, RH services for adolescents, mother baby care package, contraception for women above 35, RTI and STI, infertility and cancer of the cervix. • Infection Control (Definition, protective barriers, housekeeping) • Management of FP Clinic Services (Facilities, staff, activities and logistic Management)	• Counseling portion lacks information on the more common misconceptions and misinformation regarding specific FP methods. This area should be strengthened since it directly affects the utilization and use-continuation of the FP methods. • NFP discussion is vague and confusing. • some of the information presented are no longer up-to-date (missed pills). The manual is monotonous in terms of lay out and content. Updates like the SDM method and auto disable syringe are not included. • no discussion on the normal menstrual cycle which is relevant to the understanding of NFP. • Why is there a need to include non program methods in the manual when these are not available in the Philippines?	information. • has a binder for ease in removal of certain sections of the manual for reference. • algorithms are included in STI syndromic approach. Tables and graphs are included which summarize the information previously discussed. It also contains information on the mode of action of each method, its contra indications, informed consent for the surgical methods and information to be given to clients in counseling. • cover is water resistant.

NAME	DATE PUBLISHED	FUND SOURCE	COVERAGE	LIMITATIONS	ADVANTAGES
5. 1993 Clinical Standards Manual	1993	DOH	• divided into 10 sections with 8 essential chapters. The contents are as follows: • Family Planning to Promote the Health of Mother and Children (Goal of Philippine FP Program, Concept of FP, Benefits of FP) • IECM in FP (introduction, goal, strategies, interviewing, counseling, misconceptions, key IECM messages) • Basic RH Care Visit (Nature and purpose, Assessment, education, lab exams) • Methods of Contraception currently used in DOH FP Clinics (VSC, IUD, OCSs, condoms, NFP) • Other Methods of Contraception not available at DOH clinics (injectables, implant contraceptives, diaphragm, cervical cap, vaginal spermicides, vaginal rings)	• less tables and graphs that summarize pertinent data (e.g. side effects and complications). • paperback cover makes it easier to damage. • too large to be brought around though. • binding makes it difficult to open and the pages more prone to tearing. • back pages are not used. This increased the number of pages	• contents are presented in outline and bullet form. Important information are highlighted in BOLD letters. • cautions such as “no, not and never” and key words (like IMMEDIATELY) are underlined (e.g. Never use force when sounding) which reduces the possibility of misreading the instructions. • information covers the whole page (not just half) of the manual. It is much easier to understand. It is symmetrical and pleasing to the eyes. • lay outing draws attention to the content of the manual and not to the spaces. • chapter headings and Sub topics are highlighted by placing these in boxes and using different font types and sizes (Arial 12, 14 and 16). . This decreases the monotony of the presentation and makes it easier to locate important information. • uses Arial for font type. Arial is

NAME	DATE PUBLISHED	FUND SOURCE	COVERAGE	LIMITATIONS	ADVANTAGES
			• Related RH Care Services (suspected pregnancies, infertility, STIs) • Infection Control (handwashing, antisepsis of the skin and MM, gloving, decontamination and cleaning, sterilization, high level disinfection, housekeeping) • ***Management of Clinic Services (Clinic facilities, staffing, provision of clinic services to clients, logistic management, records and reports)***		easier to read because it is bigger and wider. • more handy than the 1997 manual . It is thinner and narrower. • plastic binder is used which does not rust even if the manual is used for years.
6. Friendly Care Foundation Manual	2001	USAID	• in CD form, it contains the following: 1. Plans and Programs • Performance Monitoring Plan for the Cooperative Agreement covering the period Oct '01-Sept '03; • work and implementation plans to operationalize the agreement • framework for Friendly Care's core tasks in Family	• objectives of the manual are not explicitly presented. • learning expectations are not incorporated nor the skills, knowledge and attitudes that the service providers are supposed to acquire • referral agencies are not clearly identified • procedures do not have illustrations • presented in CD form.	• presentation is very comprehensive. • content is complete enough for the service provider to impart necessary information to the client. • includes diagrams to facilitate identification of clients. • individualized discussion of GATHER technique for each method of counseling • inclusion of surgical emergency

NAME	DATE PUBLISHED	FUND SOURCE	COVERAGE	LIMITATIONS	ADVANTAGES
			Planning. 2. Accomplishments • periodic Performance Monitoring Plan Report of Accomplishments • financial statements, and accomplishments in Family Planning. It also contains charts on the trends for both operational and organizational sustainability of each clinic and the institution. 3. Technical Assistance Report – contains copies of external evaluation reports of Friendly Care clinics as well as the outputs of consultants contracted to develop service protocols, programs, and management systems. 4. Promotions – contains electronic copies of the various Information-Education-Communication materials developed by Friendly Care and other partners to promote the organization, its programs,	Some service delivery points may not have computers with CD-ROM to view the contents.	procedures and emergency contraception. • all Family planning methods are included in the manual giving a complete range of choices • provision of reasons for the use of the method which enables client to make informed choices • follow-up system for each method is indicated • use of mnemonics, diagrams and tables to reduce repeated consultations.

NAME	DATE PUBLISHED	FUND SOURCE	COVERAGE	LIMITATIONS	ADVANTAGES
			and products. 5. Services and Administration –contains copies of the various service protocols developed by Friendly Care for both Family Planning and other clinic services. Administrative guidelines and protocols covering the areas of clinic management, clinic facility standards, and quality assurance		
7. Module 1: Introduction to Family Planning and the Health of Women and Children and An Overview of Family Planning Methods as part of the Comprehensive Reproductive Health and			Unit I: The Family Planning and the Health of Women and Children 1. Key messages related to child spacing and maternal and child health 2. Major principles of family planning 3. Health benefits of family planning 4. Relationship between maternal and child mortality and high risk factors of maternal age, birth order and birth interval 5. Comparison between pregnancy and child	• In the two units, the content areas gave more emphasis into knowledge but failed to expound on the "attitudes and skills" changes. As a crucial element of quality care, there is a need define and elaborate on the technical competencies required from the different service providers.	• the module is able to cover the essential topics and basic information on family planning for the different service providers. • manner of presentation offers easy reference for the trainer at any point during the topic discussion. • format is user friendly, not very voluminous or bulky compared with other existing modules. • presentation is clear, concise, and the language appropriate. • technical terms are defined • contents of this module serve as

NAME	DATE PUBLISHED	FUND SOURCE	COVERAGE	LIMITATIONS	ADVANTAGES
Family Planning Training			mortality risks with contraceptive-use mortality risks Unit II: An overview of the Family Planning Methods 1. Hormonal contraceptives including combined oral contraceptives; progestin only pills, emergency contraceptive pills, the progestin – only injectable DMPA, and norplant implants 2. IUD 3. Voluntary surgical contraception (female sterilization and vasectomy) 4. condoms 5. Lactational Amenorrhea Method 6. Fertility Awareness Methods (Rhythm or Calendar method, Basal Body temperature, Cervical Mucus method, Symptothermal method)		good reference materials on Family planning overview and method use.

5.4 Key Informants' Interviews

The highlights of the in-depth interviews of the DOH directors are as follows:

5.4.1 Since the devolution in 1990, management and operations of FP services have been transferred to local government units. DOH's functions are related to policy making, direction setting, technical assistance, training, and to a limited extent, monitoring and supervision. Local governments take charge of the operations of programmes and resources mobilization except for a few retained hospitals. Therefore, LGUs adopt the policies set by DOH or promote a specific method based on their preference.

5.4.2 The RH concept has not been operationalized in terms of the integration of the constituent elements at the service level. Although ten elements are indicated, in many clinics, only about three elements are provided – MCH (safe motherhood), FP, prevention and management of STIs including HIV/AIDS. The incremental approach has yet to be adopted due to trained manpower lack and resource constraints. Besides, the interactive linkages among the ten elements have not been illustrated and operationalized. UNFPA's project areas attempted to integrate the different elements of RH.

5.4.3 Misconceptions exist regarding FP. It is sometimes equated with abortion or loss of potency among males. These should be counteracted. FP remains a core element of RH and can be an entry point in the discussion of the other RH elements.

5.4.4 More recently, there has been an increased emphasis on natural family planning methods with concomitant need to strengthen the delivery training component.

5.4.5 Some innovations have been made in service provision including the introduction of SDM which is being implemented on a geographical staggered basis.

5.4.6 Since 1997, there have been developments in FP service management such as response to missed pills and the use of competency based standards. These need to be factored into the new manual.

5.4.7 Simplification of the manual can be achieved by veering away from the voluminous textual presentation to the use of algorithms, flowcharts, outlines, illustrations and visual presentation.

5.4.8 The uniformity in training of the staff of government and private clinics is emphasized in the light of the anticipated increase in the number of acceptors and market segmentation of clients.

5.4.9 Recommendations by the key informants for improving the manual are as follows:

a) Adopt a different format for ease in comprehension of instructions i.e. use of flowcharts or stepwise procedure for the provision of each method selected. More illustrations in presentation such as pictures, visual aids, algorithms, etc. need to be incorporated in the manual.

b) Set uniform service delivery standards for government and private clinics to ensure that there is a consensus in provision of services. This becomes pressing in the light of the shift of clients who can afford (due to contraceptive commodity problems and heavy demands on facilities) to the private sector where providers may not be exposed to the same training modality. The question raised is: will the private sector be prepared to adopt the same standards as DOH?

c) The manual needs to be updated to emphasize NFP (including SDM), fertility awareness, handling of infections, management of complications, counseling, dispelling misconceptions related to all methods, behavioral change communication, ensuring quality in service provision, WHO eligibility criteria, missed pills management and responsible parenthood.

d) There may be a need to revisit and revise records, reports and forms, such that its contents reflects the Sentrong Sigla standards and are amenable to monitoring and evaluation.

e) To operationalize the RH framework, the linkages between FP and different elements of RH need to be clearly defined. Besides, an overview of RH operations with particular focus on FP should be incorporated in the manual since most of the providers are not aware of RH and its operational mandate.

f) Add new dimensions such as:

- acetic acid wash instead of (or in addition to) pap smear because the latter is costly
- instructions on missed pills, PMAC
- updates on NFP, NSV, SDM
- WHO eligibility criteria per method including basis for referral, deferment and caution
- violence against women in relation to FP, men's role in FP, adolescent concerns related FP
- FP motivation of both men and women
- FP monitoring (Engender Health has developed a monitoring scheme for BSS)
- self assessment of providers' technical skills in the form of checklists for each method. Presently, checklists are available for pills and DMPA.

5.5 Focus Group Discussions

Highlights of the Results

5.5.1 It was noted that not all providers within one clinic utilize the same manual. For example, in one health office in Metro Manila, the two nurses utilize the manual but the physician does not use it. In a CHO in the South, the nurse uses the manual but the midwives and physician do not consult it. In one BHS, of the 6 providers, only 2 utilize the manual.

5.5.2 The providers are guided by a number of manuals in their service provision. Aside from the FP Clinical Standards Manual in 1997, other manuals used are the 1993 FP Clinical Standards Manual; Competency Based Training Manual; Basic and Comprehensive Manual; Johns Hopkins Essentials for Contraceptive Technology Friendly Care Foundation Manual; Well Family Clinic Standard Operations Manual; Quality Assurance Manual in Essential Clinical Standards for Contraceptive Service Delivery; and the WHO Eligibility Criteria Manual. (See Annexes VII and VIII)

5.5.3 While orientation was given on the use of the 1993 manual, no training was given on the use of the 1997 DOH manual. An orientation was given for one month in the use of the Basic Comprehensive FP Manual and for the Competency Based Training manual, it was for one week. There were no refresher courses provided to the 1997 manual users. Respondents mentioned that the manual was simply given to them and they depended entirely on their own interpretation of the contents.

5.5.4 The sections consulted most were categorized by service facility and provider. Nurses from the RHUs mentioned infection control because it is well discussed; methods of FP and their advantages and disadvantages; and the syndromic approach to STIs. Midwives from BHS indicated methods of FP particularly advantages and disadvantages, as well as side effects. For NGO clinics, the sections consulted most are the different FP methods particularly pills and DMPA, physical examination, history taking, infection control, and counseling.

5.5.5 The chapter least consulted by physicians is the vision, goals, objectives and Philippine components of the Family Planning programme which were perceived as not having a direct relevance to their services provision. The nurses concurred with the physicians. The second is the RH care chapters because there are better references such as CBT manual. The midwives mentioned those areas that are not under their purview such as basic RH care, counseling (because they have not received training on it), infection control since they do not insert IUD, management of FP, and pelvic examination since they have been doing it frequently that there is no need for validation in the manual. Besides, midwives tend to seek their supervisors' advice instead of consulting the manual. The heavy workload of the staff precludes frequent consultation of the manual.

Among providers in NGO clinics, nurses mentioned non-programme methods because they only discuss those available in their clinic; management of FP because they use a different protocol, with its own set-up and a computerized recording system; and counseling because of its limited discussion in the manual. Among nurses in one NGO, STIs management is not dealt with thoroughly in their programme. The same is true for counseling since there are better references that deal with the issues in detail. GATHER is not adhered to consistently because there are a lot of clients waiting to be served so that the process could not be followed through. Infection control has been part of the routine tasks of providers that there is no need to refer to the manual. Besides, IUD insertion, counseling and STI diagnosis and management are not in their clinics.

Among the hospital staff, the section least consulted is reporting and recording since this is not part of the duties of the providers and chapter 1: the vision, goals and objectives which do not have anything to do with the client.

5.5.6 Areas that are deemed necessary but not presented in the manual include: myths and misconceptions regarding family planning and ways of dispelling them, Standard Days Method protocol, emergency contraception, use of acetic acid wash, back up for missed pills; eligibility criteria for the use of each method; use of autodisposable syringe; interpretation of pap smear findings, other gynecologic problems; and emergency contraception.

5.5.7 Other comments on the manual include:

- need for updating to reflect recent developments
- presentation is too textual with less visuals and illustrations
- too bulky and heavy
- no detailed discussion on counseling
- format is too space consuming
- information conflicts with other manuals and updates (e.g. eligibility criteria, precautions and contraindications for some methods (e.g. vasectomy) and laboratory procedures
- need to update policies and programmes
- need to reflect the other elements of RH and how they cross cut with FP, myths and misconceptions related to each method, gender sensitization in FP, adolescents and male' services, updates on STIs, male oral contraceptives and Gassipol, and quality provision of services
- delete discussion on diaphragm, norplant, and female condom which are not available in clinics (Note: since these are FP methods which may be available in the future, it is important that information on their usage should be included)
- add discussions on NSV, spinal anesthesia, BTL, laparoscopy and SDM
- update record keeping and use of records for service improvement
- include waste management in FP clinics
- include referral agencies and how to make referrals.

5.5.8 There is agreement that adolescent services should be incorporated in the programme for the following reasons:

- they are at high risk of pregnancy and STI transmission because of sexual curiosity and occupational risks e.g. entertainers, prostitutes
- in case of unplanned pregnancy, they may resort to abortion

Despite the agreement, providers feel that the focus in adolescents' provision of services should be more in counseling (e.g. adverse consequences of teenage pregnancy and sexual behaviour) instead of active promotion of family planning methods. One NGO provider mentioned that they provide FP services only to married couples. Another hospital staff mentioned that the target should be the 15-16 years of age and not those who are younger. The service providers were not given orientation on counseling of adolescent clients. Information to be provided should include the effects of early pregnancy and premarital sex, menstruation, physical and sexual characteristic changes, puberty, methods of FP, STIs, risks of pregnancy, and responsible parenthood. One provider indicated that information should not be volunteered but response to individual queries can be provided.

During the validation seminar, a suggestion was made to include peri menopausal women in service provision as they may also be exposed to the risk of pregnancy.

5.5.9 There is also a consensus in the inclusion of males as clients for FP services. Their responsibility in FP usage and their role in females' use of FP methods are recognized. Besides, FP should be a joint responsibility of males and females. However, one hospital provider felt that males cannot be included in their programme since they are catering only to females.

Regarding the modality in which male FP services could be provided, the responses were:

- counseling for various RH problems
- information and education on male responsibility and services available (through seminars, lectures, counseling)
- separate clinic hours
- IEC for single males
- visual and auditory privacy

5.5.10 In general, the manual was deemed acceptable and relevant. Some of the comments drawn were:

> "It is ok for service providers. Everything is here including procedures and references" - CHO nurse

> "What impressed me most is the flowchart of the syndromic approach to STI diagnosis which I plan to reproduce and place on the wall" - CHO nurse

"The information on FP methods is complete. The presentation is clear"
- RHU nurse

"If you have doubts, you can refer to the manual for answers"
- BHS midwife

"The last (1997) edition is comprehensive"
- DOH Director

"There are markers. It is easy to look for specific methods"
- NGO clinic midwife

"The manual assures the competency in application of skills"
- NGO clinic physician

"I like the clinic management outline"
- Hospital physician

"The GATHER approach is complete. The essential skills for infection control are provided"
- Hospital physician

5.5.11 The perceived weaknesses of the manual as discerned by the service providers are:

a) Lack of summary of the key points at the end of each chapter
b) Lack of case illustrations
c) No flowchart in the provision of FP services
d) The benefits of FP are not discussed thoroughly. There is no elaboration on the myths and misconceptions regarding each method. Besides, no modality for counteracting the misinformation is provided
e) No detailed presentation is given on adolescents and male clients FP, violence against women (in relation to FP) and prevention and management of abortion complications.
f) Pictures and illustrations are not clear which could not provide guidance in the assessment of findings such as pap smear.
g) RH was not given emphasis particularly the linkages among RH elements.
h) No specific instructions on referrals were given
i) Copies are limited
j) Need for updates on policy changes and latest technical developments, medical eligibility criteria, and instructions e.g. vasectomy is not recommended for single childless men. This was reversed during the Flavier period to include childless men who want the method even if they do not have children.

6. Issues and Concerns

1. Impact of devolution on the local level adoption of the DOH endorsed manual. Under the devolved programme, DOH will be responsible for the provision of technical guidelines and standards while the local governments will provide financial assistance to the local health programmes and see through their operationalization. In many cases, the utilization of the manual hinges largely on the specific method endorsement by the local government leader.

2. Inability to operationalize the paradigm shift from FP to RH. While there is a general understanding of the policy shift from FP to RH with its ten constituent elements, the interactive linkages among the elements have not been discussed and no particular guidelines have been provided to operationalize the provision of quality, integrated FP services in collaboration with LGUs, NGOs and the private sector. In fact, some service providers did not appreciate the inclusion of the vision and goals of FP as they are deemed not to be pertinent to their tasks.

3. Inadequate distribution of the manuals. Despite the non probabilistic nature of the selection of the service delivery points in government facilities, of the 10 SDPs initially visited, the staff members from the four SDPs have not encountered the manual, three of which are Luzon based. Further substitution did not yield the desired results as the clinics identified in the provinces adjoining Metro Manila did not have the manual.

4. Use of different manuals in service provision. It was noted that the different SDPs included in the study are using two or more manuals with the indication that the other manuals are more up-to-date, comprehensive, succent in presentation and user friendly. Other manuals used are:

- Competency Based Training Manual
- FP Clinical Standards Manual
- Basic Comprehensive Family Planning Manual
- Manual in DMPA as a Contraceptive Method
- Friendly Care Manual of Operations
- Johns Hopkins Essentials for Contraceptive Technology
- Well Family Clinic Standard Operations Manual
- Quality Assurance Manual in Essential Clinic Standards for IPPF FP Resource Persons in East and Southeast Asia and Oceania
- WHO Eligibility Criteria Manual

This is aggravated by the fact that different service providers use different manuals within one unit.

5. Inability to comprehend the FP vision, goals and objectives to secure commitment to its implementation at the local level due to lack of guidelines that explain the FP linkage with the other elements and the operationalization of basic tenets. A few service

providers suggested dropping the first chapter of the manual altogether since the FP policy and framework are not relevant to service provision.

6. Staggered distribution of the manual. Many service delivery points have not received the manual and some have just received it a few months ago. This calls for a review of how regional offices are storing and distributing the manual. Monitoring of manual distribution may have to be undertaken.

7. Lack of orientation on the use of the manual. The providers were not oriented on the use of the 1997 manual. In the training, the competency based training (CBT) manual was used. Thus, the service providers varied in their interpretation of the procedures in diagnosis, service provision and management. No refresher courses were provided. Besides, the congruence between the CBT manual and the 1997 manual has yet to be assessed.

8. Some areas are deemed comprehensive in terms of guidelines provision such as infection control, syndromic approach for STI diagnosis, description of FP methods, and their advantages and disadvantages. An area that was considered not relevant is the orientation on the, vision, goal and objectives of FP programmes. Some felt that the information on counseling is not detailed enough to guide the providers since the misconceptions and misinformation related to the different methods have not been incorporated.

9. The manual has not been updated. Other FP areas not discussed in the manual include Standard Days Method, myths and misconceptions related to FP methods, emergency contraception, acetic acid wash, missed pills back-up and autodisable syringes. The WHO eligibility criteria are not adopted in screening of potential FP clients. Besides, discussions on diaphragm, norplant and female condom are considered irrelevant since they are no longer provided in the SDPs. Other areas that need to be considered include NSV, spinal anesthesia in BTL, laparoscopy, and waste disposal. Males and adolescents' FP needs are not included.

10. The presentation of the manual is not clear cut as it lacks the illustrations and algorithms required to guide the provider in service delivery. The manual is deemed heavy, bulky and lengthy. Lay out is space consuming.

11. The referral system has not been established. Where and how referrals are to be made have not been included.

12. Quality elements have not been incorporated. Given the policy statement regarding quality service provision, the constituent relevant elements of quality have not been incorporated such as information given to clients, informed choice, technical competence, interpersonal relations and referrals.

7. Recommendations

The recommendations could be categorized as:

e) those related to the adoption of the manual;
f) those related to its distribution;
g) those related to its responsiveness, relevance and utilization; and
h) those related to its monitoring.

A. Those related to the adoption of the manual

1. Launch a largescale information campaign on Reproductive Health, in general and Family Planning, in particular since many local government leaders and health service providers do not have sufficient comprehension of the RH paradigm, the niche of FP and its interactive linkages with the other elements. Most service providers are knowledgeable of the ten elements but their interactive linkages have yet to be explained.

2. Operationalize the modalities in the National Family Planning Strategy particularly the integration of the various services in a holistic fashion. Disseminate guidelines to concerned agencies.

3. Develop a plan for the enhancement of knowledge and awareness of the key influentials (local government leaders, programme managers and providers) of the importance and relevance of the manual (IEC campaign).

B. Those related to the dissemination and distribution of the manual

4. Develop a modality for largescale dissemination and distribution of the manual to ensure that the service delivery points receive the manual at the same time.

C. Those related to the improvement of the manual

5. Review and rationalize the current manuals being used by various agencies and draw from their respective strengths and the recommendations of the DOH directors and service providers to ensure that a manual that draws from the strengths of various sources and responds appropriately to current and emerging concerns is produced and adopted.

6. Improve the manual on the basis of the following recommendations:

c) Ensure clarity in presentation through
    - use of colored illustrations and pictures particularly in the presentation of pathologic conditions such as STIs and discussion of topics
    - use of larger fonts
    - use of bullets to summarize key points
    - use of checklists for each method's medical eligibility
    - precise, concise and simple words

- presentation of the anatomy and physiology of the reproductive system

d) Improve contents by:
   - addressing emerging concerns such as: adolescent FP needs, male involvement in FP, and gender sensitivity in service provision. For male services, aside from the male methods (condom, vasectomy), information and behavioral change communication related to male responsibility should be incorporated. For adolescents, counseling and information on the adverse effects of irresponsible sexual behaviour, teenage pregnancy, abortion and STIs can be included. Include nonprogramme methods (implants, diaphragm, female condom, spermicede barrier and calendar method) to provide a wide variability of information.

   - Updating and expanding service provision to include BTL through spinal anesthesia, use of autodisabled syringe, emergency contraception (e.g. FP in rape cases), dispelling myths and misinformation regarding methods, missed pills back-up, and TCu 380A in IUD provision.

   - integrating quality dimensions in FP service provision such as information given to clients, informed choice, technical competence, interpersonal relations, and referral system (continuity of services).

   - revision of counseling procedures to adapt GATHER to the local situation of clients. Streamline the approach in the light of the heavy workload of clients.

   - use of local case studies and situationers for ease in comprehension of service delivery mechanics and management

   - inclusion of the eligibility criteria from WHO standards for the different methods.

   - In the light of the new policy issuance, provide a separate chapter for NFP comprising LAM, BBT, SDM, cervical mucus method, and symptothermal method.

   - Categorize methods into barriers, hormonal, fertility awareness based, and permanent.

7. Provide algorithms and flowcharts for sequencing of actions from screening, FP service provision, management of complications/side effects, follow-up and referrals for the different methods.

8. Revise reports, records and forms to conform to the Sentrong Sigla standards.

9. Attempt to ensure uniformity in service provision standards in GO and NGO clinics as well as hospitals.

10. Prepare summary tables for every chapter.

11. Ensure congruence between training and service delivery by comparing the training and the service provision manuals or simply prepare a companion training manual to the planned revised manual

Monitoring

12. Institute a monitoring mechanism for tracking the utilization of the manual and providing backstopping in the use of the manual when the need arises.

13. Continually update the manual with the advent of new technologies and emerging needs (if possible, every three years).

14. Maintain continuous dialogue with the end users and programme planners to ensure sustained usage of the manual.

8. Concrete Suggestions for Revising the Manual

This section provides specific suggestions for revising the manual based on the results of the study and the feedback of the participants in the validation seminar held on December 12, 2003. The following outline is suggested:

8.1 Outline of the Proposed Manual

Acknowledgement
List of acronyms
List of tables and charts
Introduction

- The Revised Manual
  (short discussion, limit to a few paragraphs)
  - Objectives
  - Format and contents (in brief)
  - How to use the manual

Table of Contents

CHAPTER 1: INTRODUCTION

I. Reproductive Health framework (brief description linking Family Planning to the other elements of the RH with FP)
   A. Maternal and Child Health
   B. Women's Health
   C. Prevention and Management of Reproductive Tract Infection (through Condom use)

D. Prevention and Management of Abortion Complications arising from unwanted pregnancies
E. Cancer Prevention (Non-contraceptive benefits)
F. Adolescent RH
G. Violence Against Women and Children (pregnancy as a result of rape or abuse)
   1. Sexually abused women (Emergency Contraceptives)
   2. Domestic violence related to contraceptive use
H. Male Reproductive Health (Male Involvement in FP, and Male FP)
I. Sexuality Education (Fertility Awareness and Responsible Parenthood)
J. Family Planning in the Premenopausal Phase

II. The Philippine Family Planning Program
   A. Objectives
   B. Strategies
   C. Program Components
   D. Benefits of Family Planning (from Pathfinder and Basic Comprehensive FP Manuals; include TB control as one of the priority theses of the current DOH Programme as one of the benefits or rationale of FP (increased risk as a result of frequent childbearing)
   E. Operationalizing the Philippine Family Planning Programme and its Linkages at the Clinic Level

CHAPTER 2: QUALITY PROVISION OF FAMILY PLANNING SERVICES

Judith Bruce's Framework of Family Planning Quality Provision and its 6 elements (brief description; brief mention of COPE and Quality Assurance)

I. Choice of method
   (include table on effectiveness of different FP methods from MECCU p. 5)
II. Information given to the client towards informed choice
III. Technical competence of the different types of providers at each level of service facility and training requirements
IV. Interpersonal relations (effective counseling)
V. Follow up or continuity mechanism
VI. Appropriate constellation of services (referrals)

CHAPTER 3: INFECTION CONTROL

I. Definition
II. Protective Barriers
   A. Handwashing
   B. Antisepsis of the skin and mucus membrane
   C. Gloving for protection
   D. Decontamination and cleaning
   E. Sterilization

F. High level disinfection

III. Housekeeping including waste management and disposal

CHAPTER 4: SCREENING OF CLIENTS FOR FAMILY PLANNING SERVICES

I. Client history

II. Anatomy and physiology of the Reproductive System (Male and Female)

III. General physical examination
(emphasis should be placed on the breast and pelvic examination)
(additional topics: testicular examination, assessment of male sexual dysfunction, adolescent related hormonal changes such as irregular menses, PMS, PID, amenorrhea etc)
(a general algorithm on the physical examination should be included)

IV. Laboratory and diagnostic procedures (to be done at SDP or referred to other related units)
A. Urinalysis
B. Hemoglobin determination
C. Ph determination of vaginal discharges
D. Wet or fresh vaginal smear test
E. Gram staining
F. Schiller's test
G. Pap smear
H. Acetic acid wash
I. Pregnancy test: How to tell if a woman is pregnant (subjective and objective tests)

CHAPTER 5: COUNSELING

I. Role of counseling in family planning service delivery
(highlights interpersonal relationships as component of quality of care)

II. Essentials in counseling
A. The counseling room (dimensions, lay out, descriptions, supplies and equipment that would ensure auditory and visual privacy)
B. Skills needed for effective counseling
C. Qualities of a good counselor (e.g. eye contact, active listening etc)
(Case studies illustrating the effects of the positive and the negative behaviors of the counselor could be included to emphasize the points discussed)
D. Simulation with different clients (male, female, adolescents, etc.)

III. Responsible parenthood
A. Pre marriage counseling
B. Four pillars of responsible parenthood
C. Roles of the family and the parents

IV. The GATHER approach

(Highlight or emphasize this: Not all these elements are applied to all clients in the same way. Each individual client's needs should determine the emphasis given at each step in the counseling session. In some clients one element may need to be emphasized, others may need only a brief exposure to a specific element and in some cases a step may be skipped altogether. The approach is to be fitted to each client's needs.) (paragraph 2, p. 13 of 1997 FP Clinical Standards Manual)

A. Greet the client
B. Ask the client
C. Tell the client
D. Help the client to choose a method
E. Explain how to use a method
    1. How to use the method
    2. **Back up methods should the timing of the start of the use of the method is inappropriate (e.g. condom or NFP use for pill users who started in the middle of their cycle**)
    3. Usual side effects and their management
    4. Signs and symptoms of complications and appropriate management
    5. Myths, rumors, misconceptions and frequently asked questions about the method
F. Return visit, Follow up, and Referrals
    1. Algorithms for referral of complications
    2. Follow Up or Return Instructions
    3. How to Refer a Client
    4. Counseling Clients who decides on method discontinuance

V. Counseling on discontinuance of method (return to fertility)

CONTENT OUTLINE PER METHOD

I. Key points
II. Algorithms
III. Facility requirements (Optional)
IV. Applying the GATHER technique
Greet client
Ask client
Tell the client about the method:
a) How does it work?
b) How effective?
c) Advantages and disadvantages
Help the client decide**:** WHO Medical Eligibility Checklist
Explain
a) Nature and mechanism of action
b) Side effects and management
c) Signs and symptoms of complications and management
d) Special considerations (e.g. OCS and drug interactions)
e) Myths and misconceptions from CBT
V. Technical competence
A. Screening
B. Procedure or provision of service
VI. **R**eturn Visit , Follow up, Referrals
a) Return visit
b) Following up
c) Referrals
d) Counseling for clients who decide to discontinue methods
VII. Recording and record keeping

CHAPTER 6: FERTILITY AWARENESS BASED FAMILY PLANNING METHOD

I. Physiologic basis of the Natural Family Planning Methods (normal menstrual cycle)
II. Types of Natural Family Planning methods
A. Basal Body Temperature
B. Cervical Mucus Method
C. Symptothermal Method
D. Standard Days or Beads Method (Recent Trends)
E. Lactational Amenorrhea Method

CHAPTER 7: HORMONAL CONTRACEPTIVES

I. Oral Contraceptives
   A. Los Dose Combined Oral Contraceptives
   B. Progestin Only Oral Pills
   II. Injectables (DMPA)
   III. Norplant Implants

CHAPTER 8: BARRIER METHODS

I. Intrauterine device
II. Male Condoms
III. Female Condoms
IV. Cervical Cap
V. Diaphragm
VI. Spermicides

CHAPTER 9: PERMANENT METHODS

I. Female Sterilization
II Male Sterilization

CHAPTER 10: MALE IN VOLVEMENT IN FAMILY PLANNING

I. Motivating the male
II. Benefits of Family Planning for the male
III. Ways by which males can be involved in FP
   A. As FP acceptors
   B. As supporters to their partners (consent, support in the use-continuance of the methods of partners specially in the NFP methods)
IV. Special considerations and counseling needs of the male client
   A. Auditory and visual privacy
   B. Consultation with male counselors and providers
   C. Special clinic hours, clinic days or clinics for the male client
   D. Services other than FP (that can serve as the selling point for male clients)
      1. Male sexual dysfunctions
      2. Urologic conditions
      3. Others

CHAPTER 11: THE ADOLESCENT CLIENT

I. Pubertal Development
   A. Anatomic and physiologic changes
   B. Behavioral changes
II. Adolescent Reproductive Health Issues
   A. Peer pressure and sexual behavior

B. Sexuality and sexual activity
C. Misperceptions related to risks of sexual behaviors
D. Gender power relations in negotiations for safe sex
E. STI/ HIV AIDS risks
F. Teenage pregnancy and its consequences
(health, sociopscyhological and economic implications for the teen)

III. Management of Adolescent Reproductive Health Programme
A. Counseling
1. Mechanics of counseling the adolescent clients (ensuring confidentiality and openness)
2. Avoidance of risk behaviors
B. Referrals for services
C. Behavior change communication

CHAPTER 12: THE PERI-MENOPAUSAL CLIENT

I. Anatomic and Physiologic Changes
II. Family Planning Issues
III. Management of Problems

CHAPTER 13: MANAGEMENT OF CLINIC SERVICES
(The discussion on the 1997 manual can be retained. However revisions need to be made to ensure that the updates, new issuances policies and orders are included. An example of these are the implications of the Outreach VSS and home service package)
(The updates on the functions and tasks of the Volunteer Health Workers for home services should also be specified)

I. Facility Requirements
(Description of the facility requirements of the service delivery point as well as the services to be provided, clinic hours, size, location, population serviced; the production of a table is encouraged; this may be improved from the 1997 manual)

II. Clinic Activities
(description of the activities of the service delivery points in terms of screening, provision of service, counseling, referrals, follow ups, recording and reporting; the production of a table is encouraged)
e.g.

	BHS	RHU/ Main Health Centers	CHO	Municipal Hospital	District Hospital	Provincial Hospital	Home or Community Based Service
Screening							
Provision of Service							
Referrals…							

III. Description of Staff Roles and Functions
(including the Community Health Volunteers, VSS and itinerant team)

IV. Logistic Management
A. Listing and inventory of equipment and supplies (what is required and what is available)
(the production of a table is recommended for easy reference)
B. Maintenance of Contraceptives supply
1. Procurement procedure (including forms to be used)
2. Storage
3. Shelf life
4. Inventory

V. Record keeping and Reporting
A. Recording
1. Updated forms
(Revision of the forms to conform to the Sentrong Sigla Standards)
a. How to fill them up
2. Processing of forms to arrive at basic tabulations
3. Analysis and utilization of data for information and clinic service modification
4. Basic information
a. Client profile (trend and patterns)
b. Methods accepted
c. Side effects reported in clinic
d. Follow up and return visits
e. Use-continuation of method based on client records
f. Failure rates (accidental pregnancies) based on service statistics

APPENDIX

- WHO Medical Eligibility Criteria for Starting Contraceptive Methods (MECCU p.10)
- Classification Categories
- Algorithms for Reproductive Tract Infections
- Referral system
(discussion on referrals for FP services, Reversal of Permanent Methods and Waste Management)
- Directory of Service Delivery Points
(include the referral points, services provided, clinic hours, contact information such as name, address, phone number etc; service delivery points should include the government, non-government institutions as well as the private sector)
- Inventory of available contraceptives in both commercial and government sectors
(identify the different brands per contraceptive method)

The details are given in Annex IX.

Annexes

ANNEX I

Data Collection Instruments

1. FGD GUIDELINES

1) What family planning services are provided in your clinic?

2) When are these services provided? (State schedule and type of Family Planning services given).

3) Are you guided by any manual or materials for the provision of services? (Please mention).

4) If the Family Planning Clinical Standards manual (green manual) is mentioned, ask:
    a) When did you acquire this manual?

    b) How did you acquire it?

    c) Were you given any orientation on the use of the manual?
    No_____ Yes_____

    d) If yes, describe the orientation:

    e) Date, duration, venue, type and content of the orientation.

    f) Was the orientation adequate enough to enable you to provide Family Planning services based on the manual's contents?
    Yes_____ No _____

5) Manual's Content
    a) Do you consult the contents of the manual when you provide your services?

    b) Which are the chapters you consult the most? Why?

    c) Which are the chapter that you consult least? Why?

    d) Are there other Family Planning areas that you are dealing with which are not presented in the manual? Please describe them.

e) Since the manual's publication in 1997, have there been changes in your Family Planning Activities that necessitate their inclusion or modifications in a revised manual? Please describe them.

f) What are the weaknesses of the manual?

g) What are the areas that need to be improved, deleted, or added?

h) What are your recommendations to update or revise the manual?

i) How can we ensure the following:
   i. clarity in presentation
   ii. completeness in coverage
   iii. technical merits of the manual
   iv. ability to address emerging concerns

6. Are you using other manuals? Indicate names. What are the advantages of this/these manuals over the one published in 1997?

7. How is Family Planning linked with the overall Reproductive Health Concept in your programme? How can it be addressed in your manual?

2. SELF ADMINISTERED QUESTIONNAIRE

Name: _____
Designation: _____
Service Delivery Point: _____
Address: _____

1. What family planning services do you provide in your clinic? (Please check box and indicate schedule of delivery)
    - [ ] Lactational Amenorrhea Method _____
    - [ ] Natural Family Planning _____
        - [ ] Ovulation Method/ Cervical Mucus Method _____
        - [ ] Calendar Method _____
        - [ ] Basal Body Temperature _____
        - [ ] Sympto-thermal Method _____
    - [ ] Hormonal Contraceptives _____
        - [ ] Combined Monophasic _____
        - [ ] Combined Triphasic _____
        - [ ] Progesterone-Only_____
    - [ ] Injectables _____
    - [ ] Intrauterine Device _____
    - [ ] Condoms _____
    - [ ] Voluntary Surgical Method _____
        - [ ] Tubal Ligation/ Female Surgical Sterilization _____
        - [ ] Vasectomy/ Male Surgical Sterilization _____
    - [ ] Implant Contraceptives _____
        - [ ] Norplant _____
        - [ ] Biodegradable Implants _____
        - [ ] Injectable Microspheres and Microcapsules _____
    - [ ] Diaphragm _____
    - [ ] Female Condom _____
    - [ ] Spermicide Barriers _____
    - [ ] Client Education _____
        - [ ] Counselling _____
        - [ ] Lectures and Seminars _____
        - [ ] Dissemination of materials _____
    - [ ] Client Assessment/ Screening _____
    - [ ] Diagnostic and Laboratory _____
    - [ ] Referrals _____
    - [ ] Follow-up _____
    - [ ] Home visits _____
    - [ ] Others (Please specify) _____

2. Are you guided by any manual/ material for the provision of family planning services?
   [ ] Yes
      [ ] DOH Manual (Please specify)
      _____
      _____
      _____
      [ ] Others (Please specify)
      _____
      _____
      _____
   [ ] No

3. For each manual utilized, please continue.
   a. When did you acquire this manual? (Please specify month and year) _____
   b. How did you acquire this manual?
      [ ] Delivered to the clinic
      [ ] Requested from DOH main office/ funding qgency
      [ ] Distributed by PHO/ MHO
      [ ] Others (Please specify) _____
   c. Were you given any orientation on the use of the manual?
      [ ] Yes (Please describe)

Title of Manual	Date	Duration	Venue	Content

      [ ] No

d. What about refresher courses?

[ ] Yes (Please describe)

Title of Manual	Date	Duration	Venue	Content

[ ] No

e. Was the orientation adequate for your family planning service provision?

[ ] Yes

Why? _____

_____

_____

[ ] No

Why not? _____

_____

_____

MANUAL'S CONTENTS

A. Do you consult the contents of the manual when you provide your services?

[ ] Yes

[ ] No

Why not? _____
_____
_____

B. Which are the chapters that you consult the most? Please specify topic and reason.

[ ] Philippine Family Planning Program
Topic : _____
_____
_____
Reason: _____
_____
_____

[ ] Counselling in Family Planning

Topic : _____
_____
_____
Reason: _____
_____
_____

[ ] Basic reproductive Health care Visit
Topic : _____
_____
_____
Reason: _____
_____
_____

[ ] Methods of Family Planning
Topic : _____
_____
_____
Reason: _____
_____
_____

[ ] Reproductive health care
Topic : _____
_____
_____
Reason: _____
_____
_____

[ ] Infection Control
Topic : _____
_____
_____

Reason: _____
_____
_____

[ ] Management of Family Planning Clinic Services
Topic : _____
_____
_____
Reason: _____
_____
_____

[ ] Others
Topic : _____
_____
_____
Reason: _____
_____
_____

C. Which are the chapters that you consult the least? Please specify topic and reason.
[ ] Philippine Family Planning Program
Topic : _____
_____
_____
Reason: _____
_____
_____

[ ] Counselling in Family Planning
Topic : _____
_____
_____
Reason: _____
_____
_____

[ ] Basic reproductive Health care Visit
Topic : _____
_____
_____
Reason: _____
_____
_____

[ ] Methods of Family Planning
Topic : _____
_____
_____
Reason: _____

[ ] Reproductive health care
Topic : _____
_____
_____
Reason: _____
_____
_____

[ ] Infection Control
Topic : _____
_____
_____
Reason: _____
_____
_____

[ ] Management of Family Planning Clinic Services
Topic : _____
_____
_____
Reason: _____
_____
_____

[ ] Others
Topic : _____
_____
_____
Reason: _____
_____
_____

D. Are there other family planning areas that you are dealing with which are not presented in the manual? Please specify and describe these.
_____
_____
_____
_____
_____

E. Since the manual's publication in 1997, have there been changes in your Family Planning activities that necessitate their inclusion or modification in a revised manual? Please describe them.
_____
_____
_____
_____
_____

F. What are the weaknesses of the manual?

_____
_____
_____
_____
_____
_____
_____

G. What problems did you encounter in the use of the manual?

_____
_____
_____
_____
_____
_____
_____

H. What are the areas that need to be improved, deleted or added in the manual? Please specify.

Improved: _____
_____
_____
_____

Deleted : _____
_____
_____
_____

Added : _____
_____
_____

I. What are your recommendations to update or revise the manual? Please specify.

_____
_____
_____
_____
_____
_____

4. Are you using other manuals? Please indicate names and their advantages and disadvantages.

TITLE OF MANUAL	ADVANTAGES	DISADVANTAGES

5. How is the Family Planning linked with the overall Reproductive Health Concept in your programme?

   [ ] Integrated
   [ ] Separate Program
   [ ] Others Please Specify._____

   Please explain further.

   _____
   _____
   _____
   _____
   _____

6. What are your recommendations to ensure the following:

   a. Clarity in presentation

_____
_____
_____
_____

b. Completeness in Coverage

_____
_____
_____
_____

c. Competency in the application of the skills presented in the Manual

_____
_____
_____
_____

d. Ability to address emerging concerns

_____
_____
_____
_____

7. What are the emerging concerns, issues, or trends in Reproductive Health Care that needs to be addressed by the new manual? Please specify.

_____
_____
_____
_____
_____
_____

8. Do you think that the adolescent family planning needs should be included in the manual?

[ ] Yes.
Why do you think so? _____
_____
_____
What should be included? _____
_____
_____

9. Do you think that the male clients should be included in the manual?
[ ] Yes. Why do you think so? [ ] No. Why not?
_____
_____
_____

10. How should the male services be provided in your clinic?

    _____
    _____
    _____

11. What problems or identified family planning needs of the male client should be addressed by the new manual?

_____
_____
_____
_____
_____
_____

Thank you for your time.

3. GUIDE QUESTIONS FOR THE KEY INFORMANTS
(Department of Health Programme Managers)

1. Describe the mandate and activities of the division.

2. How is the division related to Family Planning services?

3. What are the division's tasks relative to Reproductive Health?

4. Describe the involvement of your office in the Family Planning Programme.

5. Since 1997, has there been a change in the programme that necessitated a change or modification of Family Planning service provision? Please describe.

6. How has the shift to Reproductive Health been operationalized?
   What has been the position of Family Planning within the Reproductive Health programme?

7. Have there been changes in the Family Planning service provision since 1997?

8. What manual has been or currently being used in Family Planning service delivery?

9. Do you think this manual adequately meets the evolving needs in Family Planning service provision?
   If yes, how?

   If no, why not?

10. What are the weak areas in the manual?

11. What areas need to be strengthened? How?

12. What new dimensions need to be added? Why? How could these be incorporated?

13. If the manual is to be revised, what suggestions would you like to make?

14. Were or are there other Family Planning manuals being used by Department of Health…
    At present? Specify.

15. Between 1997 and the present? Specify.

ANNEX II

Focus Group Discussion Respondents

Service Delivery Points

		Number of Staff Members who Participated in the FGD
1. Metro Manila		
	• San Isidro Health Center	3
2. Iloilo		
	• Jaro II Health Center (CHO)	5
	• Mina Health Center (RHU)	6
	• Barangay Tularokan Health Service (BHS)	8
2. Davao		
	• Davao City Health Office (CHO)	5
	• Bunawan Health Center (BHS)	3
	• Tomas Claudio Health Center (RHU)	3
3. NGO		
	• Friendly Care	2
	• Institute of Maternal and Child Health	12
	• Family Planning Organization of the Philippines	3
4. Hospital		
	• Jose Fabella Memorial Hospital	4
5. Zamboanga City		
	• Midwives from all Service delivery points (BHS, CHO, RHU and hospitals) from Tawi-tawi and Zamboanga	11

* Note: In addition, one physician from PGH was interviewed in depth.

ANNEX III

Key-informants' Interviews Respondents

1. Dr. Florencia Apale
   Center for Family and Environmental Health
   Department of Health

2. Dr. Honorata Catibog
   Center for Family and Environmetal Health
   Department of Health

3. Dr. Divina Capuchino
   Center for Family and Environmetal Health
   Department of Health

4. Dr. Myrna Cabotaje
   National Center for Disease Prevention
   Department of Health

Total number of Key Informants 4

ANNEX IV
Distribution of FGD Respondents, Service Delivery Point, Category of Provider and Geographical Location
Social Acceptance Project, 2003

								In Each Service Delivery Point								
Location	**Area**	**Service Delivery Point**	*FGD*	**Manual Encountered by the Unit**	**Utilization of the manual by the unit (t least 1 person)**	**Number of Service Providers who have encountered the manual**	**Number of service providers who utilize the manual**	**Total number of service providers**	**Total number of Nurses**	**Number of Nurses who utilize the Manual**	**Total number of Midwives**	**Number of Midwives who utilize the manual**	**Total Number of Physicians**	**Number of Physicians who utilize the manual**	**Number of BHWs**	**Number of BHWs who utilize the manual**
Government Units Service Delivery Points																
Pasay City	San Isidro	CHO	1	1	1	3	3	4	2	2	1	1	1	0	0	0
Davao	Tomas Claudio	RHU	1	1	1	3	2	3	2	2	0	0	1	0	0	0
	Bunawan	BHS	1	1	1	3	2	3	1	1	1	1	1	0	0	0
	Davao City	CHO	1	1	1	2	1	5	1	1	3	0	1	0	0	0
Iloilo	Mina	RHU	1	1	1	6	6	6	2	2	3	3	1	1	0	0
	Jaro	CHO	1	1	1	5	5	5	4	4	1	1	0	0	0	0
	Tularokan	BHS	1	1	1	2	2	6	0	0	2	2	0	0	4	0
Service Hospitals																
Metro Manila	Fabella		1	1	1	4	3	4	2	2	1	1	1	0	0	0
	PGH		1	1	1	1	1	1	0	0	0	0	1	1	0	0
Non Government Organizations Service Delivery Points																
Metro Manila and adjuncting provinces	IMCH (Clinics)		1	---	---	---	---	---	---	---	---	---	---	---	---	---	---
	Makati City	Clinic	---	1	1	2	2	3	0	0	2	2	1	1	0	0
	Kalookan City	Clinic	---	1	1	1	1	2	0	0	2	1	0	0	0	0
	Quezon City	Clinic	---	1	1	3	3	3	1	1	2	2	0	0	0	0
	Valenzuela	Clinic	---	1	1	2	2	2	0	0	2	2	0	0	0	0
	Valenzuela	Clinic	---	1	1	2	2	2	0	0	2	2	0	0	0	0
	Binangonan, Rizal	Clinic	---	1	1	2	2	2	0	0	2	2	0	0	0	0
	Antipolo, Rizal	Clinic	---	1	1	3	3	3	0	0	2	2	1	1	0	0
	IMCH (Office)		1	1	1	5	5	5	4	4	1	1	0	0	0	0
	Friendly Care		1	1	1	2	2	2	2	2	0	0	0	0	0	0
	FPOP		1	1	1	3	3	3	1	1	1	1	1	1	0	0
	Total		**13***	**19**	**19**	**52**	**48**	**64**	**22**	**22**	**28**	**22**	**9**	**6**	**4**	**0**

* 14 FGDs including one among midwives from Zamboanga del Norte, Zamboanga del Sur and Tawi-tawi numbering 11

ANNEX V

List of DOH Administrative Issuances Related To Family Planning, 1998-2002

1. Administrative Order 1-A, 1998: Establishing the Philippine Reproductive Health Programme

2. Administrative Order 24-A, 1999: Strengthening the DOH Reproductive Health Programme (Amendment to AO – 1A, 1998)

3. Administrative Order 49, 2001: Adoption of the Standard Days Method (SDM or Bead Method) as additional NFP Method from the Philippine Family Planning Programme

4. Administrative Order 50-A, 2201: National Family Planning Policy

5. National NFP Strategies Plan, 2002 – 2006

6. Administrative Order 153, 2002: Implementing Guidelines for the Creation and Operationalization of Outreach Team for Voluntary Sterilization Services

ANNEX VI

LIST OF MANUALS REVIEWED

1. Family Planning Clinical Standards Manual 1993

2. Family Planning Clinical Standards Manual 1997

3. The Essentials of Contraceptive Technology: A Handbook for Clinic Staff

4. Comprehensive Reproductive Health and Family Planning Training Curriculum Module 1: Introduction to Family Planning and the Health of Women and Children and an Overview of Family Planning Methods

5. Competency Based Family Planning Training Manual

6. Friendly Care Foundation Manual

7. Basic Comprehensive Family Planning Course: Trainer's Guide

ANNEX VII
MANUALS USED FOR FAMILY PLANNING SERVICE PROVISION BY TYPE OF PROVIDER AND SERVICE DELIVERY POINT

- **FAMILY PLANNING CLINICAL STANDARDS MANUAL 1997**

Physician

1. Iloilo Rural Health Unit (Mina Health Center)
2. Family Planning Organization of the Philippines
3. Philippine General Hospital

Nurse

1. Davao City Health Office
2. Davao RHU (Tomas Claudio Health Center)
3. Davao BHS (Bunawan Health Center)
4. Iloilo CHO (Jaro Health Center)
5. Iloilo RHU (Mina Health Center)
6. Pasay CHO (San Isidro Health Center)
7. Friendly Care
8. Institute of Maternal and Child Health (Office)
9. Institute of Maternal and Child Health (Clinic Managers)
10. Family Planning Organization of the Philippines
11. Jose Fabella Memorial Hospital

Midwife

1. Davao BHS (Bunawan Health Center)
2. Iloilo CHO (Jaro Health Center)
3. Iloilo RHU (Mina Health Center)
4. Tawi-Tawi RHU (Tampakan Health Center)
5. Tawi-Tawi BHS (Brgy. Bengao, Tongsina and Malanta Health Service)
6. Zamboanga City Health Office
7. Zamboanga RHU (Upper Calarian Health Center)
8. Dipolog City Health Office
9. Institute of Maternal and Child Health (Office)
10. Institute of Maternal and Child Health (Clinic Managers)
11. Family Planning Organization of the Philippines
12. Jose Fabella Memorial Hospital

- **FAMILY PLANNING CLINICAL STANDARDS MANUAL 1993**

Physician

1. Davao City Health Office
2. Family Planning Organization of the Philippines

Nurse

1. Davao City Health Office
2. Institute of Maternal and Child Health (Office)
3. Institute of Maternal and Child Health (Clinic Managers)
4. Family Planning Organization of the Philippines

Midwife

1. Davao City Health Office
2. Iloilo BHS (Barangay Tularokan Health Service)
3. Institute of Maternal and Child Health (Office)
4. Institute of Maternal and Child Health (Clinic Managers)
5. Family Planning Organization of the Philippines

- **BASIC COMPREHENSIVE FAMILY PLANNING MANUAL**

Physician

1. Davao BHS (Bunawan Health Center)
2. Philippine General Hospital
3. Jose Fabella Memorial Hospital

Nurse

1. Davao BHS (Bunawan Health Center)
2. Jose Fabella Memorial Hospital

Midwife

1. Davao BHS (Bunawan Health Center)
2. Jose Fabella Memorial Hospital
3. Tawi-Tawi RHU (Tampakan Health Center)
4. Tawi-Tawi BHS (Brgy. Bengao, Tongsina and Malanta Health Service)
5. Zamboanga City Health Office
6. Zamboanga RHU (Upper Calarian Health Center)
7. Dipolog City Health Office

- **COMPETENCY-BASED TRAINING MANUAL**

Physician

1. Davao RHU (Tomas Claudio Health Center)

Nurse

1. Davao City Health Office
2. Davao RHU (Tomas Claudio Health Center)
3. Iloilo CHO (Jaro Health Center)
4. Iloilo RHU (Mina Health Center)
5. Pasay CHO (San Isidro Health Center)

Midwife

1. Iloilo CHO (Jaro Health Center)
2. Iloilo RHU (Mina Health Center)
3. Pasay CHO (San Isidro Health Center)

- **TRAINING OF TRAINORS MANUAL**

Physician

1. Davao City Health Office

Nurse

1. Davao City Health Office

- **FRIENDLY CARE MANUAL OF OPERATIONS**

Nurse

1. Friendly Care

- **JOHNS HOPKINS ESSENTIAL FOR CONTRACEPTIVE TECHNOLOGY**

Physician

1. Philippine General Hospital

Nurse

1. Friendly Care
2. Institute of Maternal and Child Health (Office)
8. Institute of Maternal and Child Health (Clinic Managers)
9. Pasay CHO (San Isidro Health Center)

Midwife

1. Institute of Maternal and Child Health (Office)
2. Institute of Maternal and Child Health (Clinic Managers)
3. Pasay CHO (San Isidro Health Center)

- **WELL-FAMILY CLINIC STANDARD OPERATIONS MANUAL**

Nurse

1. Institute of Maternal and Child Health (Office)
2. Institute of Maternal and Child Health (Clinic Managers)

Midwife

1. Institute of Maternal and Child Health (Office)
2. Institute of Maternal and Child Health (Clinic Managers)

- **WHO ELIGIBILITY CRITERIA**

Physician

1. Jose Fabella Memorial Hospital

Nurse

1. Jose Fabella Memorial Hospital

Midwife

1. Jose Fabella Memorial Hospital

- **QUALITY ASSURANCE MANUAL**

Physician

1. Family Planning Organization of the Philippines

Nurse

1. Family Planning Organization of the Philippines

Midwife

1. Family Planning Organization of the Philippines

- **MANUAL ON DMPA AS CONTRACEPTIVE METHOD**

Midwife

1. Tawi-Tawi RHU (Tampakan Health Center)
2. Tawi-Tawi BHS (Brgy. Bengao, Tongsina and Malanta Health Service)
3. Zamboanga City Health Office
4. Zamboanga RHU (Upper Calarian Health Center)
5. Dipolog City Health Office

ANNEX VIII
SUMMARY OF CURRENT FAMILY PLANNING MANUALS USED BY SERVICE DELIVERY POINT AND PROVIDER

- **DAVAO CITY HEALTH OFFICE**

Physician

1. Family Planning Clinical Standards Manual 1993
2. Training of Trainors Manual

Nurse

1. Family Planning Clinical Standards Manual 1993
2. Family Planning Clinical Standards Manual 1997
3. Competency-Based Training Manual
4. Training of Trainors Manual

Midwife

1. Family Planning Clinical Standards Manual 1993

- **DAVAO RURAL HEALTH UNIT (TOMAS CLAUDIO HEALTH CENTER)**

Physician

1. Competency-based Training Manual

Nurse

1. Family Planning Clinical Standards Manual 1997
2. Competency-Based Training Manual

- **DAVAO BARANGAY HEALTH SERVICE (BUNAWAN HEALTH CENTER)**

Physician

1. Basic Comprehensive Family Planning Manual

Nurse

1. Family Planning Clinical Standards Manual 1997
2. Basic Comprehensive Family Planning Manual

Midwife

1. Family Planning Clinical Standards Manual 1997
2. Basic Comprehensive Family Planning Manual

- **ILOILO CITY HEALTH OFFICE (JARO HEALTH CENTER)**

Nurse

1. Family Planning Clinical Standards Manual 1997
2. Competency-Based Training Manual

Midwife

1. Family Planning Clinical Standards Manual 1997
2. Competency-Based Training Manual

- **ILOILO RURAL HEALTH UNIT (MINA HEALTH CENTER)**

Physician

1. Family Planning Clinical Standards 1997

Nurse

1. Family Planning Clinical Standards 1997
2. Competency-Based Training Manual

Midwife

1. Family Planning Clinical Standards Manual 1997
2. Competency-Based Training Manual

- **ILOILO BARANGAY HEALTH SERVICE (BARANGAY TULAROKAN HEALTH SERVICE)**

Midwife

1. Family Planning Clinical Standards 1997

- **ZAMBOANGA CITY HEALTH OFFICE**

Midwife

1. Family Planning Clinical Standards Manual 1997
2. Basic Comprehensive Family Planning Manual
3. Manual on DMPA as a Contraceptive Method

- **ZAMBOANGA RHU (UPPER CALARIAN HEALTH CENTER)**

Midwife

1. Family Planning Clinical Standards Manual 1997
2. Basic Comprehensive Family Planning Manual
3. Manual on DMPA as a Contraceptive Method

- **TAWI-TAWI RHU (TAMPAKAN HEALTH CENTER)**

Midwife

1. Family Planning Clinical Standards Manual 1997
2. Basic Comprehensive Family Planning Manual
3. Manual on DMPA as a Contraceptive Method

- **TAWI-TAWI BHS (BRGY. BENGAO, TONGSINA AND MALANTA HEALTH SERVICE)**

Midwife

1. Family Planning Clinical Standards Manual 1997
2. Basic Comprehensive Family Planning Manual
3. Manual on DMPA as a Contraceptive Method

- **DIPOLOG CITY HEALTH OFFICE**

Midwife

1. Family Planning Clinical Standards Manual 1997
2. Basic Comprehensive Family Planning Manual
3. Manual on DMPA as a Contraceptive Method

- **PASAY CHO (SAN ISIDRO HEALTH CENTER)**

Midwife

1. Family Planning Clinical Standards Manual 1997
2. Johns Hopkins Essentials in Contraceptive Technology
3. Competency-Based Training Manual

- **FRIENDLY CARE**

Nurse

1. Family Planning Clinical Standards Manual 1997
2. Friendly Care Manual of Operations
3. Johns Hopkins Essentials for Contraceptive Technology

- **INSTITUTE OF MATERNAL AND CHILD HEALTH (OFFICE)**

Nurse

1. Family Planning Clinical Standards 1993
2. Family Planning Clinical Standards 1997
3. Johns Hopkins Essentials for Contraceptive Technology
4. Well-Family Clinic Standard Operations Manual

Midwife

1. Family Planning Clinical Standards 1993
2. Family Planning Clinical Standards 1997
3. Johns Hopkins Essentials for Contraceptive Technology
4. Well-Family Clinic Standard Operations Manual

- **INSTITUTE OF MATERNAL AND CHILD HEALTH (CLINIC MANAGERS)**

Nurse

1. Family Planning Clinical Standards 1993
2. Family Planning Clinical Standards 1997
3. Johns Hopkins Essentials for Contraceptive Technology
4. Well-Family Clinic Standard Operations Manual

Midwife

1. Family Planning Clinical Standards 1993
2. Family Planning Clinical Standards 1997
3. Johns Hopkins Essentials for Contraceptive Technology
4. Well-Family Clinic Standard Operations Manual

- **FAMILY PLANNING ORGANIZATION OF THE PHILIPPINES**

Physician

1. Family Planning Clinical Standards Manual 1993
2. Family Planning Clinical Standards Manual 1997
3. A Quality Assurance Manual in Essentials Clinical Standards for Contraceptive Service Delivery for IPPF Family Planning Resource Persons in East and South East Asian and Oceania Region.

Nurse

1. Family Planning Clinical Standards Manual 1993
4. Family Planning Clinical Standards Manual 1997
5. A Quality Assurance Manual in Essentials Clinical Standards for Contraceptive Service Delivery for IPPF Family Planning Resource Persons in East and South East Asian and Oceania Region

Midwife

1. Family Planning Clinical Standards Manual 1993
2. Family Planning Clinical Standards Manual 1997
3. A Quality Assurance Manual in Essentials Clinical Standards for Contraceptive Service Delivery for IPPF Family Planning Resource Persons in East and South East Asian and Oceania Region

- **PHILIPPINE GENERAL HOSPITAL**

Physician

1. Family Planning Clinical Standards Manual 1997
2. Basic Comprehensive Family Planning Manual

- **JOSE FABELLA MEMORIAL HOSPITAL**

Physician

1. Basic Comprehensive Family Planning Manual
2. WHO Eligibility Criteria Manual

Nurse

1. Family Planning Clinical Standards 1997
2. Basic Comprehensive Family Planning Manual 1997
3. WHO Eligibility Criteria Manual

Midwife

1. Family Planning Clinical Standards 1997
2. Basic Comprehensive Family Planning Manual 1997
3. WHO Eligibility Criteria Manual

ANNEX IX
PROPOSED REVISION OF THE CHAPTERS ON THE FAMILY PLANNING METHODS OF THE 1997 CLINICAL STANDARDS MANUAL

REVISED CHAPTER (FAMILY PLANNING METHODS)	ITEMS TO BE ADDED	ITEMS TO BE DELETED	ITEMS TO BE IMPROVED	PROPOSED FORMAT
Chapter 6 FERTILITY AWARENESS-BASED FAMILY PLANNING METHOD **I. Physiologic Basis of Natural Family Planning** **II. Different Types of Natural Family Planning Methods** A. Basal Body Temperature B. Cervical Mucus Method C. Sympto-Thermal Method D. Standard Days Method	• Content about Menstrual Cycle and hormonal changes among females which can be found in the CBT Module			Textual

REVISED CHAPTER (FAMILY PLANNING METHODS)	ITEMS TO BE ADDED	ITEMS TO BE DELETED	ITEMS TO BE IMPROVED	PROPOSED FORMAT
E. Lactational Amenorrhea Method				
I. Keypoints to Remember	• Keypoints from Chapter 14 of The Essentials in Contraceptive Technology (pp. 14-1 and 15-1)			Textual placed in a box
II. Natural Family Planning Method Algorithm	(to be developed)		• May use LAM algorithm (p.90) but needs addition in terms of information and instructions	Algorithm
III. Counseling	• Use GATHER Technique as follows: **G**reet client **A**sk client about themselves **T**ell clients about the method: • Nature of Natural Family Planning (DOH Manual 1997,	• Client Education (p.87) • Counseling (p. 95-96) • Diagram on breastfeeding definition (p.91)		Textual

REVISED CHAPTER (FAMILY PLANNING METHODS)	ITEMS TO BE ADDED	ITEMS TO BE DELETED	ITEMS TO BE IMPROVED	PROPOSED FORMAT
	pp. 93- 94) • How do the methods work? (TECT, p. 14-4 and 15-3 to 15-4); May use the diagram of the hormonal effects of the breastfeeding on the maintenance of milk production and inhibition of ovulation (FP Clinical Standards Manual 1997, p.92) • How effective is each method? (TECT, p. 14-4 and 15-4) • Advantages and Disadvantages of each method (TECT, pp.14-6 and 15-4 to 15-5) **H**elping the client make an informed choice • Medical Eligibility Checklist (TECT, p. 14-8 to 14-9 15-6 to 15-7) **E**xplain to the clients: • When to start? (TECT, pp. 14-10) • Teaching Fertility Awareness Based Methods (TECT, pp. 14-	• Advantages and disadvantages (pp. 86, 94 and 95) • Indications and Contraindications/precautions (p. 86, 94 and 95) • Nature and mechanism (p. 84-85)		Textual and Diagram Textual Textual Checklist placed in a box Textual Textual Textual Text placed

REVISED CHAPTER (FAMILY PLANNING METHODS)	ITEMS TO BE ADDED	ITEMS TO BE DELETED	ITEMS TO BE IMPROVED	PROPOSED FORMAT
IV. Return Visit V. Recording and record keeping	10) • Explaining how to use (Mode of action from DOH Manual 1997, p. 99, 102, 108 and TECT, p.15-8 to 15-10) • Important Points for the user to remember (TECT, p. 14-17) • Questions and Answers (TECT, p. 14-18); Include correcting myths and misconceptions from CBT FP • Reasons to return (TECT, p. 14-14) **R**eferral (to be developed) • List of Referral Agencies • Mechanics for Referral • Referral forms Return visits should be discussed with the client • Following up (TECT, pp. 14-15 and 15-11 to 15-14) • Helping clients at any routine return visit a. Ask questions b. Plan for the next visit			in a box Textual Outline Textual Textual Textual Tabular Textual and record forms

REVISED CHAPTER (FAMILY PLANNING METHODS)	ITEMS TO BE ADDED	ITEMS TO BE DELETED	ITEMS TO BE IMPROVED	PROPOSED FORMAT
	• Managing any problems (TECT, p.14-16) • Recording and record keeping in CBT Module - Records - Storage - Processing and tabulation - Use of information			
Chapter 7 **HORMONAL CONTRACEPTIVES** **I. Oral Contraceptives** **A. Low Dose Combined Oral Contraceptives** I. Keypoints to Remember II. Low Dose Oral	• Key points (TECT 5-1); Include indications for use as presented in current manual (p. 110)			Textual

REVISED CHAPTER (FAMILY PLANNING METHODS)	ITEMS TO BE ADDED	ITEMS TO BE DELETED	ITEMS TO BE IMPROVED	PROPOSED FORMAT
Contraceptive Algorithm III- Counseling	(to be developed) • Use the GATHER technique as follows: **G**reet **A**sk clients about themselves **T**ell clients about the method: • How do they work ? (refer to TECT 5-3; retain mode of use in the manual, p. 110) • Advantages and Disadvantages (TECT, 5-4 to 5-5) **H**elping the client make an informed choice: • Include the medical eligibility checklist for the COCs as presented in the TECT 5-6; However may need to update as based from the WHO 2nd edition version of the FP medical eligibility criteria, (2003) – COC page 1-10. The revised /2nd edition presents in matrix format description of the personal characteristic and reproductive			Algorithm Textual Checklist placed in a box

REVISED CHAPTER (FAMILY PLANNING METHODS)	ITEMS TO BE ADDED	ITEMS TO BE DELETED	ITEMS TO BE IMPROVED	PROPOSED FORMAT
	history of client. It provides comments on the condition and specific category of the client (e.g. at initiation or continuation phase of the method)			
	Explain to the clients: • When to start (TECT, 5-9) • Give advise on common problems and how she can deal with some common problems; Provide instructions as suggested (TECT 5-14 to 15) • Important points for the client to remember on the use of COC (TECT 5-19) • Correcting Myths and misconceptions (suggest to include section on TECT 5-26)			Textual Textual and tabular Text placed in a box Textual
	Referrals (to be developed) - List of agencies - Mechanics of referral - Referral forms			Textual
IV. Technical Competence	• Providing the Low Dose			

REVISED CHAPTER (FAMILY PLANNING METHODS)	ITEMS TO BE ADDED	ITEMS TO BE DELETED	ITEMS TO BE IMPROVED	PROPOSED FORMAT
V. Return Visit	Combined Oral Contraceptive 1. Explain how to use the Low Dose COC (suggest to follow procedure described in TECT p. 5-12) 2. Give specific instructions (TECT pp. 5-12 to 5-13) 3. Suggest to consider some selected procedural points about the delivery of COCs. • Organization and Management of COC service (consider section on CBT on FP, p.117) **R**eturn visits should be discussed with clients • Helping clients at any routine return visits • Plan for next visit • Managing any problems encountered (Include presentation TECT 5-17 to 18; retain existing section or clinical standards in the manual p 122-125)			Text and tabular Textual Textual Textual Textual Textual and Tabular
VI. Recording and record keeping	Recording and record keeping found in the CBT Module			Textual and record forms

REVISED CHAPTER (FAMILY PLANNING METHODS)	ITEMS TO BE ADDED	ITEMS TO BE DELETED	ITEMS TO BE IMPROVED	PROPOSED FORMAT
	- Records - Storage - Processing and tabulation - Use of information			
B. Progestin-Only Orall Pills				
I. Keypoints to Remember	• Key Points (TECT p 6-1)			Textual
II. Progestin-Only Oral Pills Algorithm	(to be developed)			Algorithm
III. Counseling	• Use the GATHER Technique as follows G-reet A-sk the client about themselves T-ell the client about the method	• Nature (p 109)		
	• How do they work (TECT p. 6-4)	• Mechanism of Action (page 110) • Mode of Use (p.110)		Textual Textual
	• "Advantages and	• Advantages and Disadvantages		Textual

REVISED CHAPTER (FAMILY PLANNING METHODS)	ITEMS TO BE ADDED	ITEMS TO BE DELETED	ITEMS TO BE IMPROVED	PROPOSED FORMAT
	Disadvantages" (TECT, pp. 6-5 and 6-6) • "How effective? (TECT,p. 6-4) H-elp the Client Make an informed choice • WHO medical eligibility criteria (TEC 6-7) • Most women can use Progestin Only Oral Contraceptives (TECT 6-8) E-xplain to the client • Starting Progestin Only Oral Contraceptives (TECT pp. 5-10, 5-22 and 5-23) • Explaining how to use (TECT p. 6-11) • Questions and Answers (TECT pp. 6-17 to 6-18) Referrals (to be developed) - List of agencies - Mechanics of referral - Referral forms	(pp.111-112) • Contraindications or Precautions (pp112-113) • Counseling (115) • Client History and Physical Examination (p 115) • Client Education (p.115) • Injection Procedure (p. 131)	• Early Pill danger signs (ACHES) p. 119 • Drug interactions with OCs (pp.120-121)	Checklist Tabular Textual Textual Outline
IV. Return Visit	• Return visits			Textual and Tabular

REVISED CHAPTER (FAMILY PLANNING METHODS)	ITEMS TO BE ADDED	ITEMS TO BE DELETED	ITEMS TO BE IMPROVED	PROPOSED FORMAT
V. Recording and record keeping	Helping Clients at Routine Visits (TECT 6-13) Managing Any Problems (TECT 6-1) Recording and record keeping in the CBT Module - Records - Storage - Processing and Tabulation - Use of information	• Follow Up (p 131)		Textual and record forms

REVISED CHAPTER (FAMILY PLANNING METHODS)	ITEMS TO BE ADDED	ITEMS TO BE DELETED	ITEMS TO BE IMPROVED	PROPOSED FORMAT
II. Injectable Contraceptive (DMPA)				
I. Keypoints to Remember	• Key Points (TECT p 7-11) • Indications for Use (CBT Manual, Unit 1 p. 16, Appropriate Users of DMPA)			Textual placed in a box
II. DMPA Algorithm	(to be developed)			Algorithm
III. Counseling	• Use the GATHER technique as follows **G**-reet **A**-sk the client about themselves **T**-ell the client about the method • How do they work (TECT, pp.7-3) • "Thins endometrial lining as a result of the high progestin and low estrogen level, the endometrium changes, becoming atrophic and unfavorable for implantation" (CBT, Unit 1, p. 13) • Retain Mode of Use in the 1997 manual	• Nature (p 127) • Mechanism of Action (p 127) • Mode of Use (p.127) • Advantages and Disadvantages (p128-129) • Contraindications or Precautions (p129) • When to Initiate DMPA (p 130) • Client History and Physical Examination (p 130)		Textual Textual Textual

REVISED CHAPTER (FAMILY PLANNING METHODS)	ITEMS TO BE ADDED	ITEMS TO BE DELETED	ITEMS TO BE IMPROVED	PROPOSED FORMAT
IV. Technical Competence	• "Advantages and Disadvantages" (TECT, p 7) • "How effective (TECT,pp. 7-4) **H-**elp the Client Make an informed choice • WHO medical eligibility criteria (TECT pp.7-6) **E-**xplain to the client • When to start (TECT 7-7) • Advice on common problems and how she can deal with them (TECT 7-10) • Explaining specific reasons to see a nurse or a doctor (TECT 7-11) • Correcting myths and misconceptions in CBT Module **R**eferrals (To be developed) - List of agencies - Mechanics of referral - Referral forms • Giving injection and proper handling of needles and syringes	• Client Education (p. 130) • Injection Procedure (p. 131)	• Table of Side Effects and Their Manage-ment (p132)	Checklist Textual Textual Textual Textual Outline Textual Textual

REVISED CHAPTER (FAMILY PLANNING METHODS)	ITEMS TO BE ADDED	ITEMS TO BE DELETED	ITEMS TO BE IMPROVED	PROPOSED FORMAT
V. Return Visit VI. Recording and record keeping	(TECT pp.7-13) • Updates on the Autodisable Syringe • Special Considerations (CBT Manual, Unit 3, p. 37, Provision of DMPA) Dose of DMPA (CBT manual, Unit 3, p 38, Provision of DMPA, pp. 40-41) R-eturn visits • Helping Clients at Routine Visits (TECT 7-14) • Planning for Her Next Visit (TECT 7-15) • Managing Any Problems (TECT 7-15) • Retain table on side effects and their management • Recording and record keeping found in the CBT Module - Records - Storage - Processing and tabulation - Use of information	• Follow Up (p 131)		Textual Textual Textual Textual Tabular Tabular Textual and record forms

REVISED CHAPTER (FAMILY PLANNING METHODS)	ITEMS TO BE ADDED	ITEMS TO BE DELETED	ITEMS TO BE IMPROVED	PROPOSED FORMAT
Chapter 8 BARRIER METHODS I - Intrauterine Device (IUD)				
I. Keypoints	• Keypoints to remember found in The Essentials of Contraceptive Technology (TECT p.12-1)			Textual placed in a box
II. IUD Algorithm	(to be developed)			Algorithm
III. Counseling	• Use the GATHER technique as follows: **G**reet client **A**sk client about Herself	• Counseling (p.181) • Client education (pp.182-184)		
	Tell client on • How does it work? Refer to TECT p.12-4 • How effective refer to TECT pp.12-4	• Nature and Mechanism of Action (p.177)		Textual Textual Textual

REVISED CHAPTER (FAMILY PLANNING METHODS)	ITEMS TO BE ADDED	ITEMS TO BE DELETED	ITEMS TO BE IMPROVED	PROPOSED FORMAT
	• Advantages and Disadvantages refer both to TECT pp.12-5 to 6 and CBT Module pp.13-14 **H**elp client • WHO Medical Eligibility Checklist refer to TECT pp.12-17 **E**xplain to client • When she can start, how to use the IUD from TECT pp.12-12 to 13 and CBT Module pp.23-24 • Give specific instructions on what will happen during the procedure: 1. Inform her that she can expect to have some unusual changes/ reactions during a menstrual period and what she should do 2. She should regularly check on her IUD 3. Explain to her when she should see a nurse or physician for special reason	• Advantages and Disadvantages (p.178) • Components of in the Provision of the Method (pp.178-180)		Checklist Textual Textual

REVISED CHAPTER (FAMILY PLANNING METHODS)	ITEMS TO BE ADDED	ITEMS TO BE DELETED	ITEMS TO BE IMPROVED	PROPOSED FORMAT
IV. Technical Competence	(warning signs for IUD users found on CBT Module IUD Section p.27) 4. Important points for the user to remember about (refer to TECT p.12-15) • Correcting Myths and Misconceptions found in TECT pp.12-26 to 27			Textual
V. Return Visit	**R**eferrals (to be developed) - List of referrals - Mechanics of referral - Referral forms			Outline
VI. Recording and Record Keeping	• Retain current section on Provision of Method in 1997 FP Clinical Standards pp.136-147 • Include Minimum Clinical Requirements found in Unit 4 Infection Prevention and Follow-up Management found in CBT Module pp. 137-138			Textual Textual Textual

REVISED CHAPTER (FAMILY PLANNING METHODS)	ITEMS TO BE ADDED	ITEMS TO BE DELETED	ITEMS TO BE IMPROVED	PROPOSED FORMAT
	• Adopt the TECT pp.12-18 to 24 format on Management of Complications. Certain key point could be highlighted as presented in the FP Clinical standards. Integrate content of TECT in the existing ones. • **R**eturn visit: 3-6 weeks after IUD insertion found in TECT 12-17 • Recording and record keeping found in the CBT Module - Records - Storage - Processing and tabulation - Use of information			Textual Textual and record forms
II – Male Condom . Keypoints to Remember I. Condom Algorithm	• Keypoints from Chapter 11 of The Essentials in Contraceptive Technology (TECT, p. 11-1) (to be developed)			Textual placed in a box Algorithm

REVISED CHAPTER (FAMILY PLANNING METHODS)	ITEMS TO BE ADDED	ITEMS TO BE DELETED	ITEMS TO BE IMPROVED	PROPOSED FORMAT
II. Counseling	• Use the GATHER Technique as follows: **G**reet client **A**sk client about themselves **T**ell clients about the method: • Introduction to Condoms (TECT, pp. 11-3) • How do they work? (TECT, pp. 11-4) • How effective? (TECT, pp. 11-4) • Advantages and Disadvantages (TECT, p.11 –5 to 11-6) **H**elping the client make an informed choice: • Medical Eligibility Checklist (TECT, p. 11-6) **E**xplain to clients: • Explaining how to use (TECT, pp 11-9 to 11-11) • Important points for the user to remember (TECT, p. 11-15) • Questions and Answers (TECT,	• Counseling (p. 164) • Advantages and disadvantages (p. 164) • Indications and Contraindications/precautions (pp.163-164)		Textual Textual Textual Textual Checklist placed in a box Textual Text placed in a box

REVISED CHAPTER (FAMILY PLANNING METHODS)	ITEMS TO BE ADDED	ITEMS TO BE DELETED	ITEMS TO BE IMPROVED	PROPOSED FORMAT
	p. 11-16 to 11-18); Include correcting myths and misconceptions from the CBT manual **R**eferrals (to be developed) - List of agencies - Mechanics of referral - Referral forms • Providing Condoms (TECT, 11-8) • Return Visit/ Following up 1. Helping clients at any routine return visit (TECT, p. 11-12) 2. Managing any problems (TECT, pp.11-13 to 11-14) • Recording and record keeping found in the CBT Module - Records - Storage - Processing and tabulation - Use of information			Textual Outline Textual Textual Textual Textual and Tabular Textual and record forms
IV. Technical Competence V. Return Visits VI. Recording and Record Keeping				

REVISED CHAPTER (FAMILY PLANNING METHODS)	ITEMS TO BE ADDED	ITEMS TO BE DELETED	ITEMS TO BE IMPROVED	PROPOSED FORMAT
III - Female Condom				
I. Keypoints to Remember	• Keypoints to remember (to be developed)			Textual
II. Female Condom Algorithm	(to be developed)			Algorithm
III. Counseling	Use the GATHER technique as follows: **G**reet the client **A**sk the client **T**ell the client about • How does it work? (to be developed or improve the discussion on the 1997 manual) • How effective? (to be developed) • Advantages and Disadvantages (retain discussion of 1997 manual) **H**elp the client • WHO Medical eligibility checklist (to be developed) • Mode of Use (can be retained			Textual Textual Textual Checklist Textual

REVISED CHAPTER (FAMILY PLANNING METHODS)	ITEMS TO BE ADDED	ITEMS TO BE DELETED	ITEMS TO BE IMPROVED	PROPOSED FORMAT
	from the 1997 manual p.198) **E**xplain to the client • When to start? (to be developed or may be improved from the 1997 manual) • How to use? (to be developed or may be improved from the 1997 manual) • Important points for the user to remember about (to be developed or may be improved from the 1997 manual)			Textual Textual Textual
IV. Technical Competence	• Providing the Female Condom (to be developed)			Textual
V. Return visit	**R**eferrals (to be developed) - List of agencies - Mechanic of referrals - Referral forms • Helping clients at any routine visit (To be developed) • Managing any problems (To be developed) • Record and record keeping			Textual Tabular Textual Textual Record and

REVISED CHAPTER (FAMILY PLANNING METHODS)	ITEMS TO BE ADDED	ITEMS TO BE DELETED	ITEMS TO BE IMPROVED	PROPOSED FORMAT
VI. Record and record keeping	found in the CBT Module - Records - Storage - Processing and tabulation - Use of information			record forms

REVISED CHAPTER (FAMILY PLANNING METHODS)	ITEMS TO BE ADDED	ITEMS TO BE DELETED	ITEMS TO BE IMPROVED	PROPOSED FORMAT
IV - Cervical Cap I. Keypoints to Remember II. Cervical Cap Algorithm III. Counseling	• Keypoints to remember found in the TECT p.13-1 (to be developed) Use the GATHER technique as follows: **G**reet the client **A**sk the client **T**ell the client about • How does it work? (TECT pp. 13-4) • How effective? (TECT p. 13-4) • Advantages and Disadvantages (TECT pp. 13-5 to 13-6) **H**elp the client • WHO Medical eligibility checklist (TECT p. 13-8) **E**xplain to the client • When to start Cervical Cap? (TECT p. 13-9) • How to use? (TECT p. 13-12 to			Textual Algorithm Textual Textual Textual Checklist Textual

REVISED CHAPTER (FAMILY PLANNING METHODS)	ITEMS TO BE ADDED	ITEMS TO BE DELETED	ITEMS TO BE IMPROVED	PROPOSED FORMAT
	13-13) • Important points for the user to remember about (TECT p. 13-17) • Specific reasons to return to the provider (p. 13-13) • Questions and Answers (TECT pp. 13-18 to 13-19) **R**eferrals (to be developed) - List of agencies - Mechanic of referrals - Referral forms			Textual Outline Textual Textual Textual
IV. Technical Competence	• Providing the Cervical cap (TECT p. 13-9)			Textual
V. Return visit	• Helping clients at any routine visit (TECT p 13-4) • Managing any problems (TECT pp. 13-15 to 13-16)			Textual Tabular
VI. Record and record keeping	• Record and record keeping found in the CBT Module - Records - Storage - Processing and tabulation - Use of information			Record and record forms

REVISED CHAPTER (FAMILY PLANNING METHODS)	ITEMS TO BE ADDED	ITEMS TO BE DELETED	ITEMS TO BE IMPROVED	PROPOSED FORMAT
Diaphragm				
I. Keypoints to Remember	• Keypoints to remember found in the TECT p.13-1			Textual
II. Diaphragm Algorithm	(to be developed)			Algorithm
III. Counseling	Use the GATHER technique as follows: **G**reet the client **A**sk the client **T**ell the client about • How does it work? (TECT pp. 13-4 and retain the contents on Mechanism of Action in the manual) • How effective? (TECT p. 13-4) • Advantages and Disadvantages (TECT pp. 13-5 to 13-6) **H**elp the client • WHO Medical eligibility checklist (TECT p. 13-8) **E**xplain to the client • When to start Diaphragm?	• Advantages (p. 193) • Indications and precautions (p. 193)		Textual Textual Checklist Textual

REVISED CHAPTER (FAMILY PLANNING METHODS)	ITEMS TO BE ADDED	ITEMS TO BE DELETED	ITEMS TO BE IMPROVED	PROPOSED FORMAT
	(TECT p. 13-9) • How to use? (TECT p. 13-11) • Important points for the user to remember about (TECT p. 13-17) • Specific reasons to return to the provider (p. 13-13; retain contents of letter c and e of client education in the manual, p. 194 – 195) • Questions and Answers (TECT pp. 13-18 to 13-19) **R**eferrals (to be developed) - List of agencies - Mechanic of referrals - Referral forms • Providing the Diaphragm (TECT p. 13-9) • Helping clients at any routine visit (TECT p 13-4) • Managing any problems (TECT pp. 13-15 to 13-16; may retain contents in the	• Mode of use (p. 191 to 192)		Textual Outline Textual Textual Textual Textual Textual Tabular
IV. Technical Competence V. Return visit				

REVISED CHAPTER (FAMILY PLANNING METHODS)	ITEMS TO BE ADDED	ITEMS TO BE DELETED	ITEMS TO BE IMPROVED	PROPOSED FORMAT
VI. Record and record keeping	manual, p 195) • Record and record keeping found in the CBT Module - Records - Storage - Processing and tabulation - Use of information			Record and record forms

REVISED CHAPTER (FAMILY PLANNING METHODS)	ITEMS TO BE ADDED	ITEMS TO BE DELETED	ITEMS TO BE IMPROVED	PROPOSED FORMAT
VI - Spermicides				
I. Keypoints to Remember	• Keypoints to remember found in the TECT p.13-1 (to be developed)			Textual
II. Spermicides Algorithm				Algorithm
III. Counseling	Use the GATHER technique as follows: **G**reet the client **A**sk the client **T**ell the client about			
	• How does it work? (TECT pp. 13-4 and retain the contents on Mechanism of Action in the manual)			Textual
	• How effective? (TECT p. 13-4) (may opt to adapt the table comparing the effectivity of the vaginal methods in TECT 13-4)			Textual
	• Advantages and Disadvantages (TECT pp. 13-5 to 13-6)	• Indications and precautions (p. 198-199)		Checklist
	Help the client • WHO Medical eligibility			Textual

REVISED CHAPTER (FAMILY PLANNING METHODS)	ITEMS TO BE ADDED	ITEMS TO BE DELETED	ITEMS TO BE IMPROVED	PROPOSED FORMAT
IV. Technical Competence V. Return visit	checklist (TECT p. 13-8) **E**xplain to the client • When to start Spermicide? (TECT p. 13-9) • How to use? (TECT p. 13-11) • Retain Precautions of the 1997 manual • Important points for the user to remember about spermicides(TECT p. 13-17) • Specific reasons to return to the provider (p. 13-13; retain contents of letter c and e of client education in the manual, p. 194 – 195) • Questions and Answers (TECT pp. 13-18 to 13-19) **R**eferrals (to be developed) - List of agencies - Mechanic of referrals - Referral forms	• Mode of use (p. 198)		Textual Outline Textual Textual Textual Textual Textual Textual Tabular

REVISED CHAPTER (FAMILY PLANNING METHODS)	ITEMS TO BE ADDED	ITEMS TO BE DELETED	ITEMS TO BE IMPROVED	PROPOSED FORMAT
VI. Record and record keeping	• Providing the Diaphragm (TECT p. 13-9) • Helping clients at any routine visit (TECT p 13-4) • Managing any problems (TECT pp. 13-15 to 13-16; may retain contents in the manual, p 195) • Table on Complications and Management (may be retained from 1997 manual) • Record and record keeping found in the CBT Module - Records - Storage - Processing and tabulation - Use of information			Textual Textual Tabular Record and record forms

REVISED CHAPTER (FAMILY PLANNING METHODS)	ITEMS TO BE ADDED	ITEMS TO BE DELETED	ITEMS TO BE IMPROVED	PROPOSED FORMAT
VII - Norplant Implants I. Keypoints to Remember II. Norplant Impants Algorithm III. Counseling	• Keypoints to remember found in the TECT p.8-1 (to be developed) Use the GATHER technique as follows: **G**reet the client **A**sk the client **T**ell the client about • How does it work? (TECT pp. 8-4 and retain the contents on Mechanism of Action in the manual) • How effective? (TECT p. 8-4) • Advantages and Disadvantages (TECT pp. 8-4 to 8-6) **H**elp the client • WHO Medical eligibility checklist (TECT pp.8-6 to 8-8)	• Nature of implant contraceptives (p. 186) • Mode of use (p. 187) • Advantages(p.187) • Indications (p. 187)		Textual Algorithm Textual Textual Checklist

REVISED CHAPTER (FAMILY PLANNING METHODS)	ITEMS TO BE ADDED	ITEMS TO BE DELETED	ITEMS TO BE IMPROVED	PROPOSED FORMAT
IV. Technical Competence V. Return visit VI. Record and record keeping	**E**xplain to the client • When to start Norplant implants? (TECT pp. 8-10 to 8- 11) • How to use? (TECT pp. 8-14 to 8-15) **R**eferrals (to be developed) - List of agencies - Mechanic of referrals - Referral forms • Providing the Norplant implants (TECT pp. 8-12 to 8-13) • Helping clients at any routine visit (TECT p8-16) • Managing any problems (TECT pp.8-17 to 8-20) • Record and record keeping found in the CBT Module - Records - Storage - Processing and tabulation - Use of information	• Client education (p.187) • Follow up (p.189)		Textual Textual Outline Textual Textual Textual Record and record forms

REVISED CHAPTER (FAMILY PLANNING METHODS)	ITEMS TO BE ADDED	ITEMS TO BE DELETED	ITEMS TO BE IMPROVED	PROPOSED FORMAT
<u>Chapter 9</u> **PERMANENT METHODS** **A. Female Fertilization**				
I. Keypoints to Remember	• Keypoints in the The Essentials of Contraceptive Technology p. 9-19			Textual placed in a box
II. Facility Requirement	Facility Requirement found in the Guidelines to Minilaparotomy			Textual
III. Female Sterilization Algorithm	(to be developed)			Algorithm
IV. Counseling	• Use the GATHER technique as follows: **G**reet Client **A**sk client about herself **T**ell the client**:** • How does it work? • How effective?	• Counseling (p.171) • Client Education (p.172)		Textual

REVISED CHAPTER (FAMILY PLANNING METHODS)	ITEMS TO BE ADDED	ITEMS TO BE DELETED	ITEMS TO BE IMPROVED	PROPOSED FORMAT
	(The Essential Of Contraceptive Technology p. 9-4) : • Advantages and Disadvantages from The Essentials of Contraceptive Technology pp.9-4 to 9-5 **H**elp the client make an informed choice • WHO Medical Eligibility Checklist pp. 9-6 to 9-11 **E**xplain how to use the chosen method • Definition and Mechanism of Action (from the Introduction to Minilaparotomy found in the manual entitled Guidelines to Minilapaprotomy pp.60-61) • Correcting Myths and Misconceptions from CBT Module **R**eferrals (to be developed) - List of agencies	• Replace the content of Advantages and Disadvantages(p.168-169) because it is outdated. • Replace the content of Nature and Mechanism of Action (pp.167-168) because it lacks essential information like the overview of the procedures, and it is outdated.		Textual Checklist placed in a box Textual Textual Outline

REVISED CHAPTER (FAMILY PLANNING METHODS)	ITEMS TO BE ADDED	ITEMS TO BE DELETED	ITEMS TO BE IMPROVED	PROPOSED FORMAT
V. Technical Competence a. Screening b. Anesthesia Regimen c. Surgical Team d. Procedure Protocol e. Management of complications f. Emergency Procedures VI. Return Visit VII. Recording and Record Keeping	- Mechanics of referral - Referral forms • Content/ Information regarding screening, anesthesia regimen, surgical team, surgical protocol, management of complications, and emergency procedures will be obtained from the Guidelines to Minilaparotomy pp. 41-101 • Return Visit/ Following Up (from the Following Up found in The Essentials of Contraceptive Technology pp.9-18) • Recording and record keeping found in the CBT	• Components of the Provision of the Method		Textual and Tabular Textual Tabular Textual Textual Textual Textual Textual and record forms

REVISED CHAPTER (FAMILY PLANNING METHODS)	ITEMS TO BE ADDED	ITEMS TO BE DELETED	ITEMS TO BE IMPROVED	PROPOSED FORMAT
	Module - Records - Storage - Processing and tabulation - Use of informatiom			
B. Male Sterilization (Vasectomy) I. Keypoints to Remember II. Facility Requirement III. Vasectomy Algortihm IV. Counseling	• Keypoints from Chapter 10 of The Essentials in Contraceptive Technology (TECT, p. 10-1) (to be developed) (to be developed) • Use GATHER technique as follows: **G**reet client **A**sk client about themselves **T**ell clients about the method: • Introduction to vasectomy			Textual placed in a box Textual Algorithm Textual Textual

REVISED CHAPTER (FAMILY PLANNING METHODS)	ITEMS TO BE ADDED	ITEMS TO BE DELETED	ITEMS TO BE IMPROVED	PROPOSED FORMAT
	(TECT, p. 10-3) • How do they work? (TECT, p. 10-4) • How effective? (TECT, p. 10-4) • Advantages and disadvantages (TECT, pp.14-4 to 10-5) **H**elping the client make an informed choice: • Medical Eligibility Checklist (TECT, pp. 10-8 to 10-9) **E**xplain to clients: • Having a vasectomy (TECT pp. 10-10 to 10-11) • Important points for the user to remember (TECT, p. 10-16) • Questions and Answers (TECT, p. 10-17); Include correcting myths and misconceptions from the CBT manual **R**eferrals (to be developed) - List of agencies - Mechanics of referrals - Referral forms • Components in the provision of	• Nature of Vasectomy (p. 177) • Mechanism of action (p.177) • Advantages and Disadvantages (p. 178) • Indications (p. 177)		Textual Checklist placed in a box Textual Text placed in a box Textual Outline

REVISED CHAPTER (FAMILY PLANNING METHODS)	ITEMS TO BE ADDED	ITEMS TO BE DELETED	ITEMS TO BE IMPROVED	PROPOSED FORMAT
V. Technical Competence a.) Screening b.) Procedure Protocol V. Return Visit VI. Recording and Record keeping	the method (DOH Manual 1997, pp. 178 to 181) • Providing Vasectomy 1. The Vasectomy Procedure (TECT, p. 10-11) 2. Explaining Self-Care (TECT, pp. 10-12 to10-13) • Following up 1. Helping clients at any routine return visit (TECT, p. 10-14) 2. Managing any problems (TECT, pp.10-14 to 10-15) • Recording and record keeping found in the CBT Module - Records - Storage - Processing and tabulation - Use of information			 Textual Textual Textual Tabular Textual and record form